Improving Care for Co-Occurring Psychological Health and Substance Use Disorders

An Implementation Evaluation of the Co-Occurring Disorders Clinician Training Program

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Report Documentation Page		*Form Approved* *OMB No. 0704-0188*

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1. REPORT DATE **2015**	2. REPORT TYPE	3. DATES COVERED **00-00-2015 to 00-00-2015**
4. TITLE AND SUBTITLE **Improving Care for Co-Occurring Psychological and Substance Use Disorders: An Implementation Evaluation of the Co-Occurring Disorders Clinician Training Program**		5a. CONTRACT NUMBER
		5b. GRANT NUMBER
		5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)		5d. PROJECT NUMBER
		5e. TASK NUMBER
		5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) **RAND Corporation,National Defense Research Institute,1776 Main Street, P.O. Box 2138,Santa Monica,CA,90407-2138**		8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)		10. SPONSOR/MONITOR'S ACRONYM(S)
		11. SPONSOR/MONITOR'S REPORT NUMBER(S)
12. DISTRIBUTION/AVAILABILITY STATEMENT **Approved for public release; distribution unlimited**		
13. SUPPLEMENTARY NOTES		
14. ABSTRACT		
15. SUBJECT TERMS		

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT **unclassified**	b. ABSTRACT **unclassified**	c. THIS PAGE **unclassified**	**Same as Report (SAR)**	**170**	

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std Z39-18

Preface

Co-occurring substance abuse and psychological health disorders are increasingly common in military populations. These co-occurring disorders (CODs) pose a growing concern for the health and readiness of U.S. military service members. Evidence suggests that integrated treatment of CODs—that is, treatment that brings together the treatment of both the substance use and psychological health disorders—may be more effective than treating each disorder separately or sequentially.

The Hazelden Co-Occurring Disorders Program (CODP) is a clinician training program designed to train clinicians to provide integrated treatment for individuals with CODs. The CODP will herein refer to Hazelden's approach to treating CODs, which involves both CODP training for clinicians as well as CODP materials. Recognizing the increasing need for effective treatment for CODs among its service members, the Navy's Bureau of Medicine contracted with Hazelden to train staff within Navy Substance Abuse Rehabilitation Programs to deliver the CODP. The goal of the training program was to help Navy clinicians respond to the needs of persons who have both substance abuse and psychological health disorders.

To assess the effectiveness of this training, RAND researchers conducted an implementation evaluation of the program. RAND's evaluation of the Navy's CODP program had two components: (1) to understand the CODP training approach and program goals and (2) to describe the implementation of the CODP, including (a) describing the Hazelden training program and materials and trainee perceptions of the training, (b) identifying which program elements were implemented and sustained at treatment sites, (c) identifying facilitators and

barriers to successful implementation of the CODP, and (d) describing programs' capability to provide integrated care.

The results of this report should be of particular interest to national policymakers within the Department of Defense and within the specific military services who are working to maintain the readiness and psychological health of service members and who are interested in approaches to improving care for service members with co-occurring psychological health and substance abuse disorders. This report is one of a series of program evaluations conducted as part of the "Innovative Practices for Psychological Health and Traumatic Brain Injury" project; for more information and to access other products from this project, please visit the project web page (http://www.rand.org/multi/military/innovative-practices.html).

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Background

In recent years, the prevalence of psychological health conditions among military service members has increased substantially (Institute of Medicine, 2013). Posttraumatic stress disorder (PTSD), for example, has emerged as one of the most common psychological health conditions among younger veterans who were deployed to Iraq and Afghanistan in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. Studies have shown that symptoms of PTSD among veterans frequently co-occur with substance use problems, leading to poorer overall health, and a greater difficulty reintegrating into civilian life.

Patients with co-occurring psychological health and substance abuse conditions have unique treatment needs, and evidence suggests that integrated treatment for these conditions—that is, treatment that brings together the treatment of both the substance use and psychological health disorders—may be more effective than treating each condition separately or sequentially. Patients who do not receive integrated care for co-occurring disorders (CODs) are at risk for poorer outcomes chiefly because the care provided does not address the interrelationship between the psychological health and substance use disorders.

Recognizing the need for integrated treatment of CODs among Navy service members, the Navy's Bureau of Medicine (BUMED) contracted with Hazelden, a nonprofit organization that specializes in training clinical personnel, to deliver an evidence-based intervention for treating patients with CODs. The Navy arranged for Hazelden per-

sonnel to train staff from Navy Substance Abuse Rehabilitation Programs (SARPs) to develop competence in delivering integrated care for CODs. SARPs are located at Navy installations around the world and typically include a mix of staff (e.g., mental health providers, addiction counselors), clients (e.g., combat-exposed and nonexposed), and services provided (e.g., medication management, assessment services, continuing care).

The Hazelden training is known as the Co-Occurring Disorders Program (CODP). The CODP will herein refer to Hazelden's approach to treating CODs, which involves both CODP training for clinicians as well as CODP materials. The CODP is based on the evidence-based Integrated Dual Disorder Treatment (IDDT) model, which was developed by the Dartmouth Psychiatric Research Center for people with severe psychiatric disorders and co-occurring substance use disorders. The CODP is an adaptation of the IDDT, developed by Hazelden for individuals with nonsevere mental health disorders. The IDDT has been tested in randomized controlled trials in civilian (but not military) populations (Drake et al., 1997, 1998). However, the CODP as adapted by Hazelden has not yet been tested in a randomized controlled trial. This program consists of several components that integrate evidence-based approaches to treatment for CODs, including motivational enhancement therapy (MET), twelve-step facilitation (TSF), and cognitive behavioral therapy (CBT). In addition, it includes modules to guide clinic administrators in enhancing their clinic's capability to effectively assess and treat CODs, to educate providers about medication management, to implement evidence-based assessment and screening procedures, and to integrate family therapy into treatment when appropriate.

The trainings first began in 2008. Since then, there has been no systematic evaluation of whether and how the CODP has been implemented and the degree to which it has translated into improved care for Navy personnel with CODs.

Purpose of This Report

RAND researchers evaluated the implementation of the training among SARP personnel. The aims of our evaluation were (1) to understand the CODP approach and program goals and (2) to describe the implementation of the CODP, including (a) describing the Hazelden training program and materials and trainee perceptions of the training, (b) identifying which program elements were implemented and sustained at treatment sites, (c) identifying facilitators and barriers to successful implementation of the CODP, and (d) describing programs' capabilities to provide integrated care.

This report presents the results of our evaluation and makes recommendations for improving future training of SARP personnel to provide integrated treatment for CODs as well as to improve the quality of care delivered to service members with CODs.

Methods

The evaluation team used four procedures to collect data on the CODP and its implementation:

1. Key-informant discussions involving two highly placed individuals with unique knowledge of the CODP and the training process: the Navy SARP Director and the Hazelden Manager of Special Projects, who served as Hazelden's main liaison with the Navy.
2. A web survey of those who attended the training. A total of 36 trainees completed the survey, resulting in an adjusted response rate of 32 percent (number of completes divided by 114 eligible respondents).
3. Telephone discussions with SARP staff. Seven of the 36 individuals who completed the survey participated in follow-up phone discussions with RAND staff.
4. Site visits. RAND staff visited three SARPs, where we conducted standardized evaluations of each site's capability to provide inte-

grated treatment for CODs. Site visits included observations of the program environment, discussions with SARP staff, discussions with clients, and medical record reviews, which were obtained with informed consent and without identifying information.

Key Findings

Understanding the CODP Training Approach and Goals

Key-informant interviews indicated that the Navy's goal for the CODP was to provide SARP staff with training in an evidence-based approach to delivering integrated treatment for CODs. The Navy supported this approach by sending SARP staff from a range of military installations to receive training at Hazelden.

Implementation of the CODP

Trainee perceptions of the CODP. Trainees generally expressed positive views of the training. In particular, informants reported that the training left them feeling confident about their ability to implement the CODP materials at SARPs. Informants also generally expressed the view that the training met or exceeded their expectations. Areas for improvement were also noted, including:

- a need for refresher trainings and CODP supervision post-training
- a need for more information about how to tailor the program for specific patient populations, such as service members with high levels of combat exposure or severe mental illness
- the need for all SARP staff to receive some training in the program to increase service-wide buy-in and support for the CODP
- a desire for more time observing Hazelden practitioners implementing the tenets of the CODP during training
- the need for information on how to modify the approaches taught by the CODP for shorter-term treatment.

Program elements that were implemented and sustained. The survey and interviews indicated that the most frequently used program elements were the screening and assessment materials, as well as portions of the CBT and ICT (Integrating Combined Therapies) curricula. The least-frequently used components were the administrator's guide and the medication management materials. In general, informants reported that they generally did not implement all elements of the approach to treating COD taught by CODP but instead selected components they believed would be most useful and tailored the materials for client needs. Some also expressed the view that it would be helpful to standardize implementation of the materials as much as possible across SARPs.

Facilitators and barriers to successful implementation. Reports from all sources suggested that several factors aided implementation of the COD treatment approach taught by the CODP. These included:

- the high quality and usability of the CODP materials
- sufficient staffing, resources, and time to implement the program
- receiving supervision in how to implement the program
- having SARP counselors with adequate training
- encouragement from SARP directors, supervisors, and fellow staff members to use the CODP materials.

Barriers reported by participants included difficulty collaborating with mental health clinics, as well as staff and leadership resistance to implementing the program. In addition, a low perceived need for the COD treatment approach taught by the CODP at certain SARPs led to a weaker implementation effort.

The level of integrated care delivered at SARPs. Informants reported that, in general, most SARPs that were assessed in this evaluation do not appear to be providing integrated care for CODs. Over one-half of survey respondents rated their SARPs as providing addiction-only services. Data from the site visits were consistent with this finding: Of the three SARPs visited by RAND researchers, one was rated as dual-diagnosis capable, while the other two were rated as pro-

viding addiction-only services. The facilitators and barriers noted above were also related to SARPs' rating as dual-diagnosis capable.

Recommendations for Improving Provider Training and Care for CODs

Based on the findings from all of our data gathering efforts, RAND researchers developed the following recommendations for improving the future training of clinicians in how to provide integrated care for CODs and for improving treatment of service members with CODs. While this evaluation focused on the CODP, our recommendations are intended to apply to the treatment of co-occurring disorders within the military health system (MHS) more generally. It was outside the scope of the evaluation to make recommendations about the future of the CODP, as the evaluation focused on implementation of the program rather than its effectiveness. Rather, these recommendations can be used to inform the development of and future investments in programs like the CODP that aim to improve the delivery of integrated care for service members with CODs.

Improving Provider Training

Recommendation 1. Develop a training plan that specifies how the training will be implemented and sustained, obtain leadership support, plan for staff turnover, provide consultation after training, and evaluate training efforts.

Recommendation 1a. Select a clinician training program that provides ongoing consultation and implementation support. When selecting a clinician training, it is essential to ensure the content is appropriate and relevant for the targeted clinicians. Training programs that provide ongoing consultation and implementation support are more desirable, as it is not unusual for clinicians to attend a didactic workshop training and not reach competence in delivering an intervention.

Recommendation 1b. Obtain organizational support from leadership prior to initiating training. Developing a training plan in advance that includes obtaining "buy-in" from senior leadership (at both the base

and the clinic levels) should increase the impact of the training. SARP administrators were invited to attend the trainings, but attendance was optional, so not all administrators attended.

Recommendation 1c. Develop a consistent approach to training relevant staff and strategies to address future staff turnover. The plan should also address which staff should be trained and include an active plan to address staff turnover and reassignments. For the CODP, civilian contractors were not trained because they could not travel to the training. On-site or online training methods would help to ensure that contractors, who often stay at a particular site for longer periods than active-duty clinicians, receive training as well. Military staff turnover is routine; therefore, clinician training must be responsive to this. Lengthy offsite training, which tends to be higher in cost due to travel and time away, may not be the most appropriate approach for staff who may be reassigned to a new position in three years.

Recommendation 1d. Provide consultation following the training. Likelihood of successful implementation would be increased if trainees received ongoing consultation or supervision to reach competence.

Recommendation 1e. Develop an evaluation plan to support assessing the success of the training. Evaluating the training is essential and needs to be planned ahead of the implementation.

Recommendation 2. Ensure that clinician training focuses on materials and skills that are most relevant to the site's clinical practice.

This evaluation suggested that the training provided by Hazelden was well received. The CODP training could be improved by focusing on particular components of the materials that have the best evidence base and are most relevant to the site's clinical practice. As our findings showed, some materials (screening and assessment, CBT, and ICT) were heavily used, while others were used rarely. Given staff turnover and challenges in developing competence in new clinical skills, a narrower focus would increase the likelihood that clinicians will be able to implement the new materials effectively.

Improving Care for Service Members with CODs

The ultimate goal of the training was to improve care for service members with CODs. The following recommendations draw from the evaluation findings, as well as from the literature on improving care for CODs.

Recommendation 3. Consider requiring that all service members who receive care from a SARP be screened for substance use and psychological health problems using validated measures.

Screening should include a measure for alcohol and drug use, along with common co-occurring psychological health conditions such as depression, anxiety, and PTSD. Discussions with staff (by phone and during site visits) suggested that SARP staff may not routinely identify clients with CODs. Routine screening of service members who enter formal treatment, and those who receive less-intensive interventions, would provide a mechanism to systematically identify these clients.

Recommendation 4. Identify and certify select sites as providing enhanced services for service members with CODs rather than assuming that all SARPs can provide high-quality care for CODs.

The evaluation found that SARPs varied widely in terms of their capability to provide evidence-based care for CODs, suggesting a continuing need to improve quality of care for service members with CODs. It may not be the best use of resources to attempt to train all sites to deliver integrated, high-quality care for CODs, given that many sites see only a small number of clients with these conditions. An alternative to attempting to train all sites to deliver integrated, high-quality care for CODs is to identify particular sites that have the capability to deliver high-quality care and ensure that service members with CODs get treatment at those sites. This may involve transferring a service member to another base to get treatment, but we observed that this occurs regularly anyway. Individual SARPs could be reviewed and certified for COD care using a structured tool like the Dual Diagnosis Capability in Addiction Treatment (DDCAT) assessment.

Recommendation 5. Implement measures to assess the quality of care provided at SARPs, including both process and outcome measures.

There appear to be few mechanisms in place for monitoring the quality of care delivered to service members with CODs, either at indi-

vidual SARPs or across all SARPs. For example, we did not identify any measures assessing treatment process, which limits the ability to determine whether the care delivered is consistent with clinical practice guidelines. In addition, there are currently no systematic approaches for ongoing monitoring of client treatment outcomes. Outcomes monitoring provides important information on the effectiveness of the services delivered. Further, outcomes monitoring is essential to delivering measurement-based care, in which repeated assessments of client outcomes help to guide treatment delivery.

Limitations

It should be noted that this evaluation has some limitations that should be considered when interpreting the results. First, the implementation evaluation was initiated approximately two years after the last round of trainings. While this post hoc evaluation still holds value, as implementation of a new program takes time and often requires organizational change that can be slow moving, future evaluation designs may be stronger if planned in advance of the training program.

Second, we note limitations from the size and representativeness of our clinician sample. We limited the survey and interview sample to trainees with active duty, reserve, or retired military status. Due to regulatory issues, we were not able to incorporate the perspectives of civilian trainees who were not retired military or spouses of military personnel (approximately 14 percent of trainees, according to data obtained from Hazelden). In addition, nearly 40 percent of trainees did not receive the invitation to participate due to inaccurate contact information. We obtained an adjusted response rate of 32 percent. While this response rate is not unusual for a clinician survey, it should be noted that this represents only 16 percent of all trainees. Therefore, the resulting sample may be biased toward clinicians who were using the CODP materials more frequently or who were more engaged or motivated to treat CODs.

Third, the data collected for this evaluation relied largely on clinicians' self-report on their perspectives on the training and use of the

CODP materials. Due to social desirability factors, clinicians may be more likely to report favorable attitudes and increased use of the CODP materials that may not accurately reflect clinical practice. Nonetheless, clinician perspectives still provide valuable insight on the utility of training and subsequent implementation.

Finally, we note that we conducted site visits at only three Navy SARPs. Individual SARPs vary in many ways (e.g., size, resources, staffing mix) that could affect the generalizability of the site visit results. Still, these site visits provided rich, detailed information regarding what might contribute to increased implementation of the CODP materials and improved care for CODs. Despite these limitations, we believe the integration of multiple data sources, both quantitative and qualitative, provides key insights into the potential value of the CODP training program.

Concluding Observations

This report presents the results of an evaluation of a clinician training program to improve care for Navy personnel with CODs. These results suggest that clinicians perceived a need for such training, were open to receiving it, and generally viewed the training experience positively. However, the results also indicate that more careful planning and targeting of SARPs best suited to develop skills for treating CODs would improve the effectiveness of the training and, therefore, be more likely to translate into higher-quality care for service members with CODs.

Acknowledgments

Abbreviations

ADSEP	administrative separation [from the Navy]
BUMED	Navy's Bureau of Medicine
CBT	cognitive behavioral therapy
CODP	Co-Occurring Disorders Program
COD	co-occurring disorder
DDCAT	Dual Diagnosis Capability in Addiction Treatment
EBP	evidence-based practice
ICT	Integrating Combined Therapies
IDDT	Integrated Dual Disorder Treatment
LIB	Living in Balance
MET	motivational enhancement therapy
MTF	military treatment facility
PTSD	posttraumatic stress disorder
SARP	Substance Abuse Rehabilitation Program
SUD	substance use disorder
TSF	twelve-step facilitation

Introduction

This report presents the results of RAND's evaluation of a Navy initiative to improve care for co-occurring psychological health and substance use disorders among service members.

Co-Occurring Disorders Are Increasingly Common in Military Populations

The co-occurrence of psychological health and substance use disorders, often referred to as co-occurring disorders (CODs), is common. The estimated prevalence of psychiatric disorders among individuals with substance use disorders varies, ranging from 7 percent to 35 percent in general population studies, and from 17 percent to 70 percent in studies of clinical samples (Flynn and Brown, 2008). Individuals with COD typically have worse treatment outcomes and increased risk of mortality when compared with those with only one of these disorders (Bagby, Ryder, and Cristi, 2002; Burns and Teesson, 2002; Curran et al., 2007; Watkins et al., 2006). Comorbidity is also associated with high rates of both attempted and completed suicide and emergency department admissions (Aharonovich et al., 2002; Cornelius et al., 1995; Curran et al., 2003; Lynskey et al., 2004).

Posttraumatic stress disorder (PTSD), for example, has emerged as one of the most common psychological health conditions among younger veterans who were deployed to Iraq and Afghanistan in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (Bernhardt, 2009). Studies have shown that symptoms of

PTSD among veterans frequently co-occur with substance use problems, leading to poorer overall health and a greater difficulty reintegrating into civilian life (Brady et al., 2009; McDevitt-Murphy et al., 2010; Sayer et al., 2010). When comparing alcohol use between military and civilian populations with PTSD, heavy drinking was found to be significantly more common among military personnel, especially among those who had been deployed to combat zones (Bray et al., 2006). Moreover, significant increases in alcohol use have been found post-deployment compared to alcohol use pre-deployment, indicating that combat trauma and/or other deployment experiences may influence the onset of co-occurring alcohol use disorders. Prescription drug abuse among military personnel also appears to have increased in the past decade (Bray et al., 2010; Servies et al., 2012). Approximately one in ten active duty service members are estimated to misuse prescription drugs, and research suggests that those receiving treatment for anxiety or depression are approximately four times more likely to misuse prescription medications compared to those not receiving such treatment (Bray et al., 2010; Jeffery et al., 2013). Given the prevalence of CODs among service members, a recent Institute of Medicine report recommended that the Department of Defense (DoD) "should better integrate care for SUDs [substance use disorders] with care for other mental health conditions and ongoing medical care" (2012, pp. 9–10).

Integrated Treatment for Co-Occurring Disorders

Integrated treatment refers broadly to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting. Integrated treatment is a means of actively combining interventions intended to address substance use and mental disorders in order to treat both disorders, related problems, and the whole person more effectively. Evidence suggests that integrated treatment for substance use and psychological health disorders is effective and may be superior to treating the disorders separately in parallel (Drake et al., 2004; Baker et al., 2012; McCauley et al., 2012; van Dam et al., 2012). Unfortunately, most

individuals do not receive integrated treatment for CODs. Treatment may be received for one disorder only, without treatment for the other disorder. Alternatively, treatment is provided sequentially, in which one disorder is treated first, and then treatment is initiated for the other disorder. Finally, treatment may be provided in parallel, in which both disorders are treated by separate providers who attend to one disorder but not the other, typically without coordination of the treatment of these disorders (McGovern and McLellan, 2008). Patients who do not receive integrated care for CODs are at risk for poorer outcomes chiefly because the care provided does not address the interrelationship between the psychological health and SUD.

Given that CODs are common in both mental health and SUD treatment settings and that integrated treatment is most effective for this population, it is essential that treatment settings identify approaches to increasing delivery of integrated treatment. Drake, Mueser, and Brunette (2007) identified key factors that are necessary for a treatment program to increase delivery of integrated treatment. First, some treatment programs are designed with the intent to provide treatment solely for SUDs. The mission and philosophy of the treatment program must address CODs in order to set the stage for integrated treatment. Second, clinician attitudes, knowledge, and behavior must often change in order to transition to integrated COD treatment. They emphasize that such changes require support and direction from program leadership. Third, integrated programs may need to be reorganized. For example, prescription of medication may need to be handled by a single provider with training in CODs rather than by multiple providers separately prescribing for each disorder. Further, staff members need high-quality training in the provision of integrated COD treatment. Finally, Drake, Mueser, and Brunette (2007) highlight quality improvement as another area of focus for programs providing integrated treatment for CODs. Specifically, it is recommended that programs use repeated assessments to monitor patient progress to help modify treatment for those not improving. These key factors identified highlight organizational and provider variables that can either hinder or facilitate delivery of integrated treatment for COD.

Department of the Navy Responses to Substance Abuse and Psychological Health Problems

Navy Policies

The need for improved access to services addressing CODs among service members has received increasing attention over the past decade. The Institute of Medicine's 2013 report on the mental health and substance abuse needs of service members recommended that DoD improve access to services for these conditions (Institute of Medicine, 2013), and President Obama recently issued an executive order to improve access to mental health services for all service members (Obama, 2012).

However, recognition of substance abuse as a health condition that often comes bundled with psychological health problems has only recently begun to emerge. Some military policy views substance abuse as an infraction. The Navy's policy is no exception. Department of the Navy policy states, "alcohol and drug abuse undermines combat readiness and is incompatible with the maintenance of high standards of performance and military discipline. It is a severe detriment to Navy's overall mission readiness" (Chief of Naval Operations, 2009, p. 2). The Navy has a "zero tolerance" illegal drug policy: "Navy members determined to be using, possessing, promoting, manufacturing, or distributing drugs and/or drug abuse paraphernalia . . . shall be disciplined as appropriate and processed for ADSEP [administrative separation from the Navy] as required. Members diagnosed as drug dependent shall be offered treatment prior to separation" (Chief of Naval Operations, 2009, p. 5). The median time from SUD diagnosis to discharge is 133 days in the Navy, the shortest of all of the services (Servies et al., 2012). Therefore, service members with co-occurring drug use and mental health disorders have less than five months, on average, to participate in Navy-provided treatment before returning to civilian life. The same policy does not apply to service members abusing alcohol: "Alcohol dependence and alcohol abuse are recognized as treatable conditions. Referral for treatment, when there is no alcohol-related misconduct . . . should not be viewed as detrimental when recommending member for

promotion, command screen, or special assignment" (Chief of Naval Operations, 2009, p. 7).

Navy Substance Abuse and Rehabilitation Programs

To improve access to treatment for substance abuse, the Navy has established Substance Abuse Rehabilitation Programs (SARPs) at installations around the world. The primary focus of SARPs is the treatment of alcohol and drug use problems; provision of mental health treatment at SARPs is not required by the Navy. SARPs vary in number of staff, staff mix (e.g., mental health providers, addiction counselors), client type (e.g., Marines, combat exposed), number of clients, and services provided (e.g., inpatient, medication management, assessment services, continuing care). For example, based on data from 40 SARPs over the first three quarters of 2012, the number of clients screened at individual SARP clinics ranged from one to 1,268 (obtained from routine U.S. Navy Bureau of Medicine and Surgery [BUMED] tracking report). In the first quarter of 2012 alone, the number of individuals receiving treatment at each SARP ranged from zero to 596. SARPs also have varying levels of connection with other clinical services, including mental health. Some SARPs have full-time staff trained to treat both substance use and mental health disorders, while others do not. Furthermore, SARPs located at sites with large medical centers may have relatively easy access to mental health departments compared with those located within smaller installations. While we were unable to rigorously assess the collaborations between SARPs and mental health departments in this evaluation, such collaboration may contribute to implementation of the COD treatment approach taught by the CODP and should be examined in future research.

Training Naval Medical Staff to Deliver Integrated Care for CODs: The Co-Occurring Disorders Program

Amid growing recognition of the need to integrate care for service members with CODs, BUMED contracted with Hazelden, a nonprofit organization, to train staff within SARPs to deliver integrated care for CODs. Hazelden's treatment approach, known as the Co-Occurring Disorders Program (CODP) includes a clinician training program

designed to train clinicians to provide integrated treatment for individuals with co-occurring mental health and substance use disorders (McGovern et al., 2008). "The CODP" will herein refer to Hazelden's approach to treating CODs, which involves both CODP training for clinicians as well as CODP materials. The CODP is based on the evidence-based Integrated Dual Disorder Treatment (IDDT) model, which was developed by the Dartmouth Psychiatric Research Center for people with severe psychiatric disorders and co-occurring SUDs. The CODP is an adaptation of the IDDT, developed by Hazelden for individuals with nonsevere mental health disorders. The IDDT has been tested in randomized controlled trials in civilian (but not military) populations (Drake et al., 1997, 1998). However, the CODP as adapted by Hazelden has not yet been tested in a randomized controlled trial. The goal of the CODP is to "provide an educational training program that will enhance the participant's ability to respond to the needs of persons who have both substance abuse and mental health disorders" (Hazelden Publishing, 2008, Goals Tab A: Objectives & Agenda).

Evaluating Navy Implementation of the CODP

Since the training program began in 2008, there has been no systematic evaluation of whether and how the CODP was ultimately implemented. Therefore, it is unclear whether the Navy's initial investment in the training of staff from 39 SARPs resulted in increased use of the CODP by service members with CODs. In order to identify ways to improve implementation of the CODP in the future, and to sustain a high quality of care for CODs, a research team from RAND was asked to identify what helped or hindered staff in implementing the CODP (i.e., facilitators and barriers).

Therefore, the aims of our evaluation were (1) to understand the CODP training and program goals and (2) to describe the implementation of the CODP, including (a) describing the CODP training program and materials and trainee perceptions of the training, (b) identifying which program elements were implemented and sustained at

treatment sites, (c) identifying facilitators and barriers to successful implementation of the CODP, and (d) describing programs' capability to provide integrated care.

Organization of This Report

The rest of this report is organized as follows. Chapter Two presents more detail on the CODP and its components; Chapter Three describes our evaluation methods; Chapter Four presents a description of the survey participants and SARP characteristics; Chapter Five reviews findings on the perceived utility and quality of the CODP; Chapter Six describes findings on the implementation of the CODP; Chapter Seven presents the results of our investigation into the facilitators and barriers to implementation of the CODP; Chapter Eight describes findings about SARPs' capabilities to provide integrated care for CODs; and Chapter Nine presents our conclusions and recommendations.

The Design and Components of the CODP

The Hazelden Co-Occurring Disorders Program

The CODP integrates several evidence-based approaches to treatment for CODs, including motivational enhancement therapy (MET), twelve-step facilitation (TSF), and cognitive behavioral therapy (CBT). It uses evidence-based principles from IDDT, a program for individuals with severe mental disorders and co-occurring SUDs, as well. Research has shown that MET, TSF, CBT, and IDDT result in significant improvement in symptoms for clients with CODs (Baker et al., 2012; Boden and Moos, 2009; Frisman et al., 2009; Glasner-Edwards et al., 2007; Kushner et al., 2013; McGovern et al., 2008).

The CODP materials include modules to guide clinic administrators in enhancing their clinic's capability to effectively assess and treat CODs, to educate providers about medication management–related issues, to implement evidence-based assessment and screening procedures, and to integrate family therapy into treatment. Specifically, the CODP materials include the *Clinical Administrator's Guidebook*, five curricula binders, and an educational DVD for patients and their families. The curricula binders are "Screening and Assessment," "Integrating Combined Therapies," "Cognitive Behavioral Therapy," "Medication Management," and the "Family Program." Each binder includes a clinician guide, patient handouts, and a CD-ROM. Table 2.1 describes each component.

In a randomized controlled trial, patients with severe PTSD and SUD who received the CBT component showed significantly greater improvements in PTSD symptoms and engagement in therapy than

those who received individual addiction counseling (McGovern et al., 2011). *The CODP does not include exposure therapy, an evidence-based approach for the treatment of PTSD. Thus, for service members with co-occurring PTSD, other integrated treatments that include exposure therapy may be required.*

Table 2.1
Description of CODP Materials

CODP Material	Description
Clinical Administrator's Guidebook	Geared toward clinic administrators
	A bound guide and CD-ROM with reproducible forms, research articles, and other resources designed for program/agency leaders
	Discusses the use of the five curricula and the program DVD to provide an integrated treatment program
	Includes tools needed to assess, improve, and track any addiction or mental health treatment program's capacity to deliver integrated treatment services
	The CD-ROM includes background research, Web links to important resources, a sample program implementation plan, and a sample charter agreement.
Screening and Assessment	Includes a three-ring binder; removable, bound clinician's guide; and a CD-ROM with reproducible clinician handouts and forms
	Screening and assessment is the first step in the treatment process. This curriculum helps clinicians learn to detect, identify, and treat mental health disorders in the context of SUDs.
	The CD-ROM includes seven clinical assessment forms each tailored to a specific mental health disorder.

Table 2.1—Continued

CODP Material	Description
Screening and Assessment (cont.)	This component covers • the mental health disorders most prevalent among patients with SUDs • how to determine whether a mental health symptom or disorder is substance induced • how to determine the patient's stage of motivation to change • the advantages and benefits of systematic screening and how to select a screening measure • how to decide which assessment method to use.
Integrating Combined Therapies	Includes a three-ring binder; removable, bound clinician's guide; and CD-ROM with reproducible patient handouts, fact sheets, and forms ICT uses a combination of MET, CBT, and TSF. MET serves to engage change, CBT to assist change, and TSF to sustain change. The clinician's guide is divided into two parts: (1) principles and clinician education and (2) structured modules that can be customized and delivered to patients over a two- to 20-week period.
Cognitive Behavioral Therapy	Includes a three-ring binder; removable, bound clinician's guide; and a CD-ROM with reproducible patient handouts, fact sheets, and forms The clinician's guide uses CBT principles to address the most common mental health disorders that are presented in addiction treatment settings, such as depression, anxiety, social phobia, and PTSD.

Table 2.1—Continued

CODP Material	Description
Medication Management	Geared toward prescribing providers
	Includes a three-ring binder with hard copies of reproducible content and a CD-ROM
	The Medication Management curriculum is a valuable resource for medical directors and clinicians. It contains vital, current information about the complex issues of medication management, including • the mental health symptoms that can accompany alcohol or drug intoxication and withdrawal • ways to collaborate with the patient to prepare a medication plan and techniques to encourage a patient's adherence • how to use treatment strategies tailored to the patient's stage of change • ongoing monitoring of mental health and substance use symptoms • best practices in initiating medication treatment and providing continuing care.
	The CD-ROM contains an easy-to-use reference on specific medications. The indications, administration, side effects, drug interactions, and other relevant prescribing information are described for each medication.
Family Program	Includes a three-ring binder; removable, bound clinician's guide; and CD-ROM with reproducible patient handouts
	Helps clinicians involve patients and family members in treatment
DVD: *A Guide for Living with Co-Occurring Disorders: Help and Hope for Clients and Their Families*	This 90-minute DVD educates clients and their family members, reinforces important concepts for clinicians, and includes four chapters: • Introduction to co-occurring disorders • Overview of various psychiatric disorders • Basics of treatment and interviews with clients and clinicians • Family component—examines the important role of family and friends in recovery.

NOTE: Adapted from Hazelden Co-Occurring Disorders Program, undated.

Navy Dissemination of the CODP

Trainings for Navy SARP staff first occurred between 2008 and 2010, beginning with addiction counselors and then shifting to mental health practitioners (Hazelden Publishing, 2009; Hazelden Publishing, 2010). SARP administrators were also invited to participate in the training. SARP staff members were not required to express an interest in treating CODs in order to attend. Instead, all SARP staff were invited to attend, but not required. Our contact at BUMED estimated that over 80 percent of SARP staff attended the training, and most expressed an interest in treating CODs. Civilian contracted staff members were not eligible to attend due to restrictions on travel for contractors. Trainees received CODP materials and attended an offsite training ranging from five to seven days at Hazelden in Center City, Minnesota. The duration of the training was shortened over time to accommodate the schedules of trainees, and in response to financial constraints.

The training included didactic and interactive sessions about the treatment program, its rationale, and components; video presentations about the CODP; practice assignments; the development of an "action plan" to implement the CODP at participants' SARPs; and live observation of assessment and treatment of CODs using the CODP at Hazelden. Per the advice of the Navy, a brief overview of the Family Program was provided, but it was not taught in detail since most SARPs do not work with families. Approximately 226 SARP staff members representing 39 SARPs were trained over this period, including SARP directors, psychologists, alcohol and drug counselors, psychiatrists, nurses, and chaplains. Some of these staff were active duty, reserve, or retired military personnel, and others were civilian government employees (Hazelden Publishing, 2010). After the training program, participants returned to their SARPs and were expected to implement the skills they had learned.

Evaluation Methods

In this chapter, we describe the procedures, measures, and analyses used to understand the CODP training, its implementation, and barriers and facilitators to implementation. We took a comprehensive approach to answering the evaluation questions using both qualitative and quantitative methods. Specifically, we used five research procedures: analysis of CODP administrative data, key informant discussions, web survey of CODP trainees, telephone discussions with SARP staff, and site visits at selected SARPs. In this chapter we first describe the CODP administrative data and use the information gained from those data to describe the cohort of individuals who received CODP training between October 2008 and May 2010. In the next section of the chapter, we describe our methods for conducting a web survey of CODP trainees, telephone discussions with SARP staff, and the SARP site visits. Finally, we describe the measures and analyses, organized by data collection method (key informant discussion, web survey, etc.).

This evaluation was reviewed and approved by the RAND Human Subjects Protection Committee. Subsequently, administrative approvals were received from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and Department of Navy Human Research Protections Program. Each military treatment facility we visited also reviewed and approved the protocol. Participants were fully informed of the purpose of the study and provided informed consent prior to participation.

Analysis of CODP Administrative Data

Hazelden routinely collects information from its trainees for program evaluation purposes. The trainees, as described in Chapter One, were clinical staff working at SARPs in various locations around the world (see Table 3.1). We reviewed self-reported data collected by Hazelden that described the 226 SARP staff who attended the CODP training between October 2008 and May 2010.

Description of CODP Trainees

According to the self-report data obtained from Hazelden, of the 226 attendees, 120 were on active duty at the time of the training; 31 were civilian government employees; and 57 were retired military personnel. Eighteen did not report their military/civilian status. Trainees represented a variety of professions, including SARP counselors, SARP directors, counseling interns, social workers, psychologists, nurse practitioners, and chaplains. They also reported a range of educational backgrounds, ranging from "some college" to doctoral degrees such as M.D.'s, Ph.D.'s, and Ed.D.'s. On average, trainees had been treating clients with SUDs for 6.8 years, yet the number of years of experience in treating clients with SUDs varied widely (range: 0–40 years). Trainees worked for DoD for an average of 15.7 years, with a range of 0.5 to 43 years. Trainees represented 39 SARPs located all over the world (see Table 3.1).

Data Collection Methods

Telephone Discussions with Key Informants

At the outset of the evaluation, we identified key informants with unique knowledge of the initiation of the CODP at Navy SARPs. The first informant was the Navy SARP Director, who was selected because he was instrumental in initiating the CODP contract and training program across SARP sites. The second informant was the

Table 3.1
SARP Locations of CODP Trainees at the Time of Training

SARP Locations	Trainees	
	N	Percentage
Total	226	100.0
Bahrain	1	0.4
Beaufort, S.C.	1	0.4
Bethesda, Md.	5	2.2
Bremerton, Wash.	9	4.0
Brunswick, Me.	3	1.3
Camp Lejeune, N.C.	17	7.6
Camp Pendleton, Calif.	18	8.0
Cherry Point, N.C.	2	0.9
Corpus Christi, Tex.	5	2.2
Dahlgren, Va.	1	0.4
Fallon, Nev.	1	0.4
Great Lakes, Mich.	9	4.0
Groton, Conn.	16	7.1
Guam	4	1.8
Henderson Hall, Va.	1	0.4
Jacksonville, Fla.	15	6.7
Kings Bay, Ga.	4	1.8
Mayport, Fla.	2	0.9
Naples, Italy	1	0.4
Washington Navy Yard, D.C.	3	1.3
Newport, R.I.	4	1.8
Norfolk/Portsmouth, Va.	21	9.4
Oak Harbor, Wash.	3	1.3

Table 3.1—Continued

SARP Locations	Trainees	
	N	Percentage
Okinawa, Japan	8	3.6
Parris Island, S.C.	3	1.3
Patuxent River, Md.	2	0.9
Pearl Harbor, Hawaii	6	2.7
Pensacola, Fla.	3	1.3
Port Hueneme, Calif.	1	0.4
San Diego, Calif.	35	15.6
Sasebo, Japan	3	1.3
Sigonella, Sicily	1	0.4
Spain	1	0.4
Tidewater Area, Va.	1	0.4
USS *Abraham Lincoln*	1	0.4
USS *Harry S. Truman*	1	0.4
Ventura County, Calif.	1	0.4
Whidbey Island, Wash.	5	2.2
Yokosuka, Japan	7	3.1
Unknown SARP	1	0.4

SOURCE: Hazelden.

Hazelden Manager of Special Projects (subsequently referred to as the Hazelden Program Manager), who was selected because of her role as the primary liaison with the Navy and as the person responsible for overseeing delivery of the training program at Hazelden. The Hazelden Program Manager maintained contact with the SARP Director and selected SARP leaders following the CODP training in order to obtain additional feedback on how CODP implementation was going at various SARPs. Both informants were involved in developing the plan for this evaluation and were aware that they would be asked to participate in telephone discussions. We conducted individual telephone discussions with each informant, which lasted approximately one hour. A RAND researcher facilitated the discussions, while a second RAND researcher took notes.

Web Survey of CODP Trainees

Of the 226 people who attended the training, we administered a web survey to those who were active duty military, reserve military, or civilian employees who were retired military personnel or spouses of a member of the Navy. Due to regulatory restrictions, we were unable to administer the survey to civilians who were not retired members of the military or spouses of military personnel. The initial survey invitation was sent via email in July 2012 to all trainees with a valid email address (136 trainees; 60.2 percent of those who attended the training) and the survey was available on the Internet for one month. Unfortunately, BUMED staff members were unable to provide alternative email addresses for those without valid email addresses. Reminders were sent to those who had not yet completed it one and two weeks after the initial invitation.

Of the 136 trainees successfully emailed, 58 (42 percent) accessed the web survey. However, 22 of these 58 individuals were ineligible for the current study because they were not active duty, reserve or retired service members, or spouses of service members at the time of the survey. This may include several who were civilian government employees whom we therefore could not include due to regulatory restrictions, but we are unable to verify this. A total of 36 trainees completed the survey, resulting in an adjusted response rate of 32 percent (number

of completes divided by 114 eligible respondents) and approximately 16 percent of all (N = 226) trainees. The adjusted response rate is not unexpected, as lower response rates are not unusual when surveying health care providers (Kellerman and Herold, 2001; VanGeest, Johnson, and Welch, 2007).

Telephone Discussions with SARP Staff

At the end of the web survey, respondents were asked if they were interested in learning more about participating in a telephone discussion. Those who indicated interest were emailed an invitation to participate in a telephone discussion. The 45–60 minute discussions gathered staff perspectives about program utility, use of materials and barriers to their use, and sustainability. A RAND researcher facilitated the discussions, and SARP staff comments and responses were transcribed by a RAND research assistant. Of the 36 individuals completing the web survey, 12 indicated willingness to be contacted to learn more about participating in a telephone follow-up discussion about their experiences with the CODP. Three of these 12 individuals subsequently declined to be interviewed, and two more did not respond to our attempts to contact them. Interviews were completed with a total of seven individuals.

Site Visits

Four SARPs were selected for site visits based on findings from the web survey about SARPs' level of adoption of CODP materials and capability to provide integrated treatment for CODs. Our goal was to maximize variability in SARPs across these dimensions. We expected that SARP size (e.g., number of clients screened/treated) and location (e.g., proximity to a large Naval medical center) would be related to the implementation of the CODP and each SARP's capability to provide integrated treatment to clients with CODs. Therefore, we selected four sites based on the web survey findings, number of clients screened and treated, and proximity to a large medical center. Additional information about the site selection methodology is available in Appendix A.

SARP Directors at each site were notified they were selected for a site visit and provided with complete information about the plans for the visit. Two RAND researchers (both clinical psychologists)

conducted the visits. Visits included a standardized evaluation of the site's capability to provide integrated treatment for clients with co-occurring mental health and substance use disorders (one of the goals of the CODP training). Site visits involved observation of the program environment, brief discussions with SARP staff, observation of client groups, brief discussions with clients, and SARP medical record review. SARP directors were asked to select ten records from a mix of clients with and without CODs for on-site record review. No identifying information was collected, and all participating staff and clients provided verbal informed consent.

Measures

Telephone Discussions with Key Informants

The key informant discussions were guided by a series of questions designed to elicit the goals and expectations of implementing the training program in the Navy, perceptions of the program's strengths and challenges, barriers and facilitators of implementation, and perceptions of the value of the program (see Appendix B: Key Informant Discussion Guide).

Web Survey

The survey (Appendix C) assessed a number of domains described below. Additional information about the selected measures, including their psychometric properties and scoring, is available in Appendix A.

Demographics and Professional Characteristics were collected including age, sex, race/ethnicity, provider type (e.g., alcohol and drug counselor, clinical psychologist), primary professional role at the SARP (clinician, administrator, both), current SARP location, and whether they were currently at the same site at the time they received CODP training.

Characteristics of SARPs were assessed using selected items from the National Survey of Substance Abuse Treatment Services (Department of Health and Human Services, 2008). Items assess types of services available at the SARP, the proportion of clients who receive

individual or group counseling, and how often various therapeutic approaches (e.g., CBT) are used at the SARP.

Implementation and perceptions of the CODP materials, and barriers to implementation were measured using the Texas Christian University Workshop Assessment Follow-Up Workshop Assessment (TCU-WAFU) (Bartholomew et al., 2007). The Workshop Assessment is a 26-item questionnaire with acceptable reliability and validity that measures use of and intentions to use training materials, program resources related to use, and barriers to use. We used the following subscales of the TCU-WAFU: the Training subscale (three items) assesses participants' views on the quality of the training; the Quality and Utilization subscale (four items) assesses training participants' views about the quality and usefulness of the materials; the Resources and Skills subscale (five items) measures participants' ability to incorporate the materials in their workplaces; the Support and Commitment subscale (five items) identifies the extent to which implementing the skills learned at the training has been supported by colleagues and senior staff, and has been sustainable; and the Barriers Encountered subscale (eight items) was used to determine why participants did not use materials in their practice. All items were rated on a five-point scale (1 = Disagree Strongly, 2 = Disagree, 3 = Undecided, 4 = Agree, 5 = Agree Strongly). Rescaled average scores were computed for the total and subscales (Bartholomew et al., 2007). To do this, the average score is computed and then multiplied by ten. Therefore, scale scores can range from 10 to 50.

To measure *frequency of use of CODP materials since the training,* we developed nine items, which were rated on a five-point scale (0 = Never, 1 = Once or twice, 2 = A few times a year, 3 = Monthly, 4 = Weekly). Respondents were asked, "Which of the following best characterizes how often you used these CODP materials since the training? Examples of 'use' include using handouts or measures in assessment or treatment, reading or reviewing the manuals, or using content to guide a session." Respondents were asked to rate the frequency with which they have used the CODP program curricula and specific program materials (total of nine items). We did not assess trainees' use of the Family Program component because it was not fully addressed in the

CODP training, as most SARPs do not work with families. To examine factors that might be associated with *overall* implementation of the CODP materials, we summed the scores of all nine variables to create an "Adoption of CODP Materials" total score. To evaluate differential implementation of screening and treatment materials, we computed indicators of (1) adoption of CODP *screening* materials, and (2) adoption of CODP *therapy* materials. The screening variable was a sum of two items: frequency of use of the CODP screening and assessment guide, and frequency of use of the CODP screening and assessment measures. The indicator of adoption of CODP therapy materials was a sum of the items assessing frequency of use of the Cognitive Behavioral Therapy and Integrating Combined Therapies guides.

The utility of the CODP was assessed using an eight-item measure created by Hazelden to assess the utility of the program. Psychometric properties are not available for this measure. Questions assess self-efficacy and achievement of different program objectives. Items are rated on a four-point scale, where 4 = Strongly agree, 3 = Somewhat agree, 2 = Somewhat disagree, 1 = Strongly disagree. The first three items were asked only of respondents who reported serving in administrative roles. Because the items assess diverse concepts, these items were examined individually.

Respondents also reported on the *supervision and additional training to support implementation of the CODP* they received after the Hazelden training. Specifically, respondents were asked whether they had *ever* received any clinical supervision to help perform assessments or deliver treatment using the CODP materials. If they answered "yes," they were also asked to report which modality of supervision was received (e.g., live observation, face-to-face meetings with supervisor, supervisor listened to audio recordings of sessions), and to estimate the number of CODP supervision sessions they had received since the training (0 = None, 1 = 1–5, 2 = 6–10, 3 = 11–15, 4 = 16–20, 5 = 21 or more). Finally, respondents reported the number of other trainings on CODs they had attended since the CODP training at Hazelden.

Attitudes about the adoption of evidence-based practices (EBPs) were measured with the 15-item Evidence-Based Practice Attitude Scale, which has acceptable reliability and validity (Aarons, 2004). This mea-

sure was selected since resistance to using EBPs could be a barrier to implementation of the CODP. In addition to the subscale scores, a total score was calculated (14 items), reflecting global attitude toward the adoption of EBPs. Respondents were asked to answer each question based on a 0–4 scale (0 = Not at all; 1 = To a slight extent; 2 = To a moderate extent; 3 = To a great extent; 4 = To a very great extent). Mean scores were used for analyses including attitudes total and subscales.

Attitudes about treating clients with CODs were assessed with the Clinician Attitudes Questionnaire (Hunter et al., 2005). This measure consists of seven items (e.g., "there is little to be done for clients that are mentally ill"), which are rated on a five-point scale (1 = Strongly Disagree, 2 = Somewhat Disagree, 3 = Neither Disagree nor Agree, 4 = Somewhat Agree, 5 = Strongly Agree). A mean attitudes score was computed (Hunter et al., 2005). This measure was selected since negative attitudes about individuals with mental health problems (e.g., "People with mental illness have weak personalities") can serve as barriers to delivering effective treatment for CODs.

Attitudes about treating clients with SUDs were measured with the Brief Substance Abuse Attitude Survey (Chappel, Veach, and Krug, 1985). This is a 20-item survey derived from the longer Substance Abuse Attitude Survey. These items are rated on a five-point scale (1 = Strongly Disagree, 2 = Disagree, 3 = Uncertain, 4 = Agree, 5 = Strongly Agree). This measure was selected because negative attitudes about clients with SUDs could be another barrier to effective implementation of the CODP. This measure consists of five subscales, which assess respondent beliefs about substance use, attitudes about substance abuse interventions, common substance abuse stereotypes, views on the utility of substance abuse treatment, and moral issues around substance abuse.

Participants who were SARP administrators were asked to assess the *capability of their SARP to provide services for clients with CODs* using the Dual Diagnosis Capability in Addiction Treatment, version 4.0 (DDCAT). The DDCAT is a 35-item measure that was developed to assess capability to assess and treat CODs and to guide addiction treatment providers in enhancing services for persons with CODs. The reliability and validity of the DDCAT are acceptable (McGovern,

Matzkin, and Giard, 2007). The DDCAT was presented and described to CODP trainees at the training. The DDCAT was designed to be rated by trained observers who use information from a variety of sources (e.g., staff and client interviews, observation of clinic materials and procedures, chart review) to compute scores across the seven domains. However, because it was not possible for the research staff to visit every site, we asked SARP administrators to rate their own SARPs on the web survey. Self-administered DDCAT scores tend to be positively biased (i.e., toward more desirable scores) by about one point on average (Lee and Cameron, 2009). We modified DDCAT items to be appropriate for self-report (as opposed to observer rated) and for the SARP setting. We consulted with the primary author of the DDCAT (Mark McGovern), who reviewed the modifications.

The DDCAT includes 35 items that are rated on a Likert scale. The individual items assess the extent to which a site is able to provide COD treatment. Example items include "Are patients with mental health disorders expected and welcomed at your SARP?" and "To what extent is education about psychiatric disorders, their treatment, and their interaction with substance use & its treatment offered at your SARP?" The ratings range from 1 to 5, where 1 indicates that the SARP is capable of providing little to no treatment for mental health conditions, 3 indicates that the site can provide some COD treatment, and 5 indicates that the site provides comprehensive COD treatment. The DDCAT consists of seven subscales, which assess a SARP's program structure, program milieu (referring to whether patients with CODs are welcomed), assessment of CODs, treatment of CODs, ability to provide continuity of care, staffing, and training. We computed mean subscale scores for each DDCAT subscale. Then, we averaged the mean subscale scores to create a total score for the SARP, which can range from 1 (Addiction Only Services) to 5 (Dual Diagnosis Enhanced) and indicates the site's overall level of dual diagnosis capability.

Telephone Discussions with SARP Staff

Each discussion focused on participants' opinions about the program materials, barriers to use, and sustainability of materials (see Appendix

D: Staff Discussion Guide). The discussion covered domains similar to the web survey but allowed us to collect more-detailed information.

Site Visits

Although we included the DDCAT in the survey, the tool is predominantly used as a structured site visit tool. The DDCAT is the most frequently used tool to assess a site's capability to provide integrated care for clients with COD, and has been implemented across a number of states (Substance Abuse and Mental Health Services Administration, 2011). The DDCAT guides on-site data collection about the program's services from a variety of sources: (1) ethnographic observations of the milieu, physical settings, and client therapy groups and sessions; (2) focused but open-ended discussions of agency directors, clinical supervisors, clinicians, support personnel, and clients/consumers; and (3) review of documentation such as medical records, program manuals, brochures, daily patient schedules, telephone intake screening forms, and other relevant materials. The characteristics and scoring of the DDCAT are described above.

Two RAND researchers trained to administer the DDCAT attended each site visit and used information gathered during discussions, observations, and record review to inform a dual diagnosis capability score using the DDCAT. After the site visit, each of the two DDCAT raters independently scored the DDCAT using the published scoring protocol (Substance Abuse and Mental Health Services Administration, 2011). The raters then came together to discuss their scoring, reconcile any discrepancies, and determine final DDCAT scores.

Data Analyses

We integrated multiple sources of data to address the evaluation questions. In this section, we describe our approach to analyzing quantitative data from the web survey, qualitative data from discussions with staff and key informants, and our approach to presenting information gathered from the site visits.

Web Survey of CODP Trainees

We evaluated descriptive statistics (e.g., means, standard deviations, frequencies) for demographic and professional characteristics, in addition to SARP site characteristics (these results were presented earlier in this chapter). We also used descriptive statistics to evaluate trainee perceptions of the CODP training and materials. We assessed the level of adoption of CODP materials using descriptive statistics, analysis of variance, and correlational analyses to examine relationships with demographic and professional characteristics. Specifically, we evaluated whether gender, race/ethnicity, or type of SARP position (e.g., administrative/clinical versus clinical only) were associated with adoption of the CODP materials (mean total adoption score). In addition, we examined the correlation (Pearson, two-tailed) between age and CODP adoption (mean total adoption score).

To assess barriers and facilitators to adoption of CODP materials, we used descriptive statistics to describe several variables, including practical barriers and facilitators, receipt of supervision and additional COD trainings, attitudes toward EBPs, and attitudes toward patients with psychological health and substance use disorders. We also correlated the total adoption score, the adoption of screening materials score, and the adoption of treatment materials score with measures of barriers and facilitators to implementation and the attitudinal measures. We had insufficient statistical power to conduct more-complex tests due to the small sample size ($n = 36$). In addition, the time between CODP training and web survey participation ranged from two to four years and could act as a barrier or facilitator to implementation. However, we were unable to identify the date each participant attended the training, so could not examine this in our analyses.

Telephone Discussions with SARP Staff

We reviewed the discussion notes in order to identify, label, and group responses relevant to each evaluation aim. Staff responses with similar concepts were grouped together. In addition to general themes, we extracted staff responses pertaining specifically to barriers and facilitators of implementation of the CODP. We provide a description of these results as they relate to each evaluation aim.

Telephone Discussions with Key Informants

We reviewed the notes from each of the discussions and extracted key themes pertaining to each of the evaluation aims. Given that each of the two key informants had a unique perspective, their responses were not combined. We provide a description of these results as they relate to each evaluation aim.

Site Visits

Similar to our approach with the telephone discussion and key informant interviews, we identified barriers and facilitators to implementation of CODP materials at each site. In addition, we used descriptive statistics on total DDCAT score, subscores, and percentage of criteria met to qualify for Addiction Only Services, Dual Diagnosis Capable, and Dual Diagnosis Enhanced designations for each site.

Description of Survey Participants and SARP Characteristics

In this chapter, we describe the SARP staff members who participated in the web survey and discussions.

Survey Respondents

Demographic and Professional Characteristics

A total of 36 individuals completed the survey. Thirteen were active duty or in an active status (36 percent), and 23 were retired service members (64 percent). Compared to nonrespondents, respondents were more likely to be retired service members ($\chi^2(1) = 6.48$, $p = .01$). Demographics of the survey respondents are shown in Table 4.1. Respondents were predominantly male, non-Hispanic white, retired service members. The majority of survey respondents (75 percent, $n = 27$) were Navy alcohol and drug counselors (ADCs). Six were level one ADCs, and 21 were level two. The remaining respondents included certified drug abuse counselors/licensed chemical dependency counselors ($n = 5$), clinical social workers ($n = 2$), a psychiatrist ($n = 1$), and a family medicine physician ($n = 1$). The majority of respondents (97 percent) reported serving in a clinical capacity: 20 respondents were counselors/clinicians, 15 were both counselors/clinicians and SARP administrators, and only one was a SARP administrator and not a counselor/clinician.

Table 4.1
Demographic Characteristics of Survey Respondents (*N* = 36)

Characteristic	*N*	Percentage	
Gender			
Male	26	72.2	
Female	10	27.8	
Race/Ethnicity			
Non-Hispanic, White	20	55.6	
Black	7	19.4	
Other[a]	4	11.1	
Hispanic, White	3	8.3	
Age	**Mean**	**Minimum**	**Maximum**
	45.8	30	65

[a] Includes Asian, American Indian/Alaskan Native, and more than one race.

SARP Characteristics

The majority of respondents (64 percent) were located at the same SARP at which they were located when they participated in the CODP training (Table 4.2). The number of respondents from each SARP ranged from one to four. Because the number of respondents from each SARP varied, it is important to note that these descriptions of SARP services may slightly overrepresent the characteristics of certain SARPs (i.e., those with more survey respondents).

Substance abuse–related services were among the most commonly endorsed, while mental health–related services were among the least likely to be endorsed. Respondents reported on the types of services provided at their SARP (Table 4.3). Nearly 95 percent of respondents indicated their SARP provides comprehensive substance abuse assessment or diagnosis, yet less than 40 percent indicated their SARP provided comprehensive mental health assessment or diagnosis. Further, only 31 percent reported their SARP offered medications for psy-

Table 4.2
Current SARPs of Survey Respondents (*N* = 36)

SARP Locations	*N*	Percentage
Camp Lejeune, N.C.	4	11.1
Camp Pendleton, Calif.	3	8.3
Dahlgren, Va.	1	2.8
Groton, Conn.	2	5.6
Jacksonville, Fla.	3	8.3
Key West, Fla.	2	5.6
Mayport, Fla.	1	2.8
Mid-South, Tenn.	1	2.8
Naples, Italy	1	2.8
Navy Drug and Alcohol Counselor School, San Diego, Calif.	1	2.8
Norfolk/Portsmouth, Va.	3	8.4
Okinawa, Japan	1	2.8
Parris Island, S.C.	1	2.8
Patuxent River, Md.	1	2.8
Pensacola, Fla.	2	5.6
Point Loma, Calif.	1	2.8
San Diego, Calif.	4	11.1
Washington Navy Yard, D.C.	2	5.6
Yokosuka, Japan	1	2.8
Other—BUMED Detachment Falls Church	1	2.8

chiatric disorders. While it is possible that these services are provided elsewhere at the same MTF, it suggests that there may be barriers to receiving care for co-occurring mental health problems.

Table 4.3
SARP Services Provided (*N* = 36 respondents)

Services Provided by SARP	*N*	Percentage
Substance abuse education	36	100.0
Screening for substance use	35	97.2
Comprehensive substance abuse assessment or diagnosis	34	94.4
Aftercare/continuing care	34	94.4
Case management	34	94.4
Discharge planning	30	83.3
Social skills development	25	69.4
Mental health education	23	63.9
Screening for mental health	22	61.1
Interim services for clients when admission is not possible	20	55.6
Self-help groups	20	55.6
Smoking cessation medications	17	47.2
Mentoring/peer support	16	44.4
Comprehensive mental health assessment or diagnosis	14	38.9
Medication-assisted therapy	13	36.1
Outreach to persons in the community who might need treatment	12	33.3
Medications for psychiatric disorders	11	30.6

Respondents also reported on the treatment approaches provided at their SARP (Table 4.4). Results suggest that group counseling was provided more frequently than individual counseling. Yet nearly 28 percent of respondents report that less than one-half of their patients receive individual therapy, and 11 percent reported less than one-half of their patients received group therapy. This suggests that some service members seen at SARP do not receive any individual or group

psychotherapy. The reasons for this are unclear, but possible explanations include that some service members are screened at one SARP and then referred to another (perhaps due to capacity or geographical issues), the service member may be receiving other treatment (e.g., medication) that is working well, the service member may have refused counseling, or there may be a waitlist for counseling. Nearly all respondents reported that substance use counseling and relapse prevention were delivered, yet fewer endorsed that other approaches were delivered often. For each of the evidence-based therapeutic approaches included in the CODP, over 50 percent reported that they were delivered often or always. Given that the majority of respondents indicated that service members at their SARP receive either group or individual therapy, these results suggest that there may be opportunities to increase the frequency with which evidence-based interventions are delivered. Finally, 31 percent of respondents indicated that their SARP offered a special program for clients with COD. This is consistent with the key informant interview with the SARP Director, which suggested that particular SARPs specialize in treating service members with COD and that often service members with COD can be transported to these sites to receive COD treatment.

Table 4.4
Treatment Approaches Provided at Respondents' SARPs (N = 36)

Treatment Modality	N	Percentage
Individual counseling		
Received by more than 75 percent of clients	22	61.1
Received by 51 percent to 75 percent of clients	4	11.1
Received by 25 percent to 50 percent of clients	5	13.9
Received by 25 percent or less of clients	3	8.3
Not offered	2	5.6
Group counseling		

Table 4.4—Continued

Treatment Modality	*N*	Percentage
Received by more than 75 percent of clients	31	86.1
Received by 51 percent to 75 percent of clients	1	2.8
Received by 25 percent to 50 percent of clients	2	5.6
Received by 25 percent or less of clients	1	2.8
Not offered	1	2.8
Substance use counseling		
Always or often	33	91.7
Sometimes	0	0.0
Never or rarely	1	2.8
Not familiar with this approach	1	2.8
Twelve-step facilitation		
Always or often	20	55.6
Sometimes	11	30.6
Never or rarely	4	11.1
Not familiar with this approach	1	2.8
Supportive counseling		
Always or often	25	69.4
Sometimes	7	19.4
Never or rarely	2	5.6
Not familiar with this approach	1	2.8
Cognitive behavioral therapy		
Always or often	23	63.9
Sometimes	8	22.2
Never or rarely	4	11.1
Not familiar with this approach	1	2.8

Table 4.4—Continued

Treatment Modality	N	Percentage
Contingency management or motivational incentives		
Always or often	10	27.8
Sometimes	16	44.4
Never or rarely	4	11.1
Not familiar with this approach	5	13.9
Motivational interviewing		
Always or often	22	61.1
Sometimes	12	33.3
Never or rarely	1	2.8
Not familiar with this approach	0	0.0
Combined cognitive behavioral therapy, motivational interviewing, twelve-step facilitation for treating co-occurring disorders		
Always or often	18	50.0
Sometimes	10	27.8
Never or rarely	8	22.2
Not familiar with this approach	0	0.0
Relapse prevention		
Always or often	30	83.3
Sometimes	5	13.9
Never or rarely	1	2.8
Not familiar with this approach	0	0.0
Special co-occurring disorders program		
Yes	11	31
No	24	69

SARP Staff Interviewees

Interviews were completed with a total of seven individuals. These included four males and three females, and two active duty/active status and five retired service members. Four interviewees were non-Hispanic white, two were Hispanic white, and one was black. One interviewee was a certified drug abuse counselor, and the other six were Navy level two alcohol and drug counselors. Three of the seven interviewees were counselors/clinicians, and four were both administrators and counselors/clinicians. The mean age of interviewees was 44.2 years (SD = 8.7).

SARPs Selected for Site Visits

Details on how we selected SARPs for site visits are contained in Appendix A. Table 4.5 shows how the four selected sites represented use of CODP materials, capability to provide care for CODs (based on web survey DDCAT data), and SARP size. Site visits to three of the four sites were completed October to November 2012. Unfortunately, due to unforeseen circumstances, we were not able to conduct a visit at Site B.

The following are characteristics of the sites we selected based on these criteria:

- Site A: Self-rated low CODP adopters, no web survey DDCAT; over 2,000 clients screened in 2011
- Site B: Self-rated high CODP adopters, Dual Diagnosis Capable; over 1,000 clients screened in 2011
- Site C: Self-rated low CODP adopters, Addiction Only services; over 200 clients screened in 2011
- Site D: Self-rated high CODP adopters, Dual Diagnosis Capable; under 100 clients screened in 2011.

Table 4.5
SARPs Selected for Site Visits

SARP Size	SARP frequency of use of CODP materials (coincides with Dual Diagnosis Capability)	
	Low	High
Large	Site A	Site B
Small	Site C	Site D

Perceived Utility and Quality of the CODP

In this chapter, we describe CODP trainee and key informant perceptions of the Hazelden training program and materials. We include results from the survey of SARP staff members who participated in the CODP training, discussions with SARP staff, and discussions with key informants.

Perceived Utility and Quality of the CODP Training and Materials

To describe the implementation of the CODP, we sought to understand key informant and trainee (SARP staff) views about the quality and usefulness of the CODP training and materials. We examined quantitative data from the survey and qualitative data from SARP staff and key informant interviews.

CODP Trainees Reported Positive Perceptions of the Training

Respondents generally agreed that the practice sessions, instructions, and examples from the CODP training provided them the confidence and ability needed to use the materials, and to train others to use the materials (Workshop Assessment Training score mean = 37.7 [possible scale range 10–50], SD = 6.3). When administrators (N = 16) were asked to assess how well the CODP training enhanced their ability to evaluate their organizational capabilities and challenges, they typically agreed that they were better able to assess areas of organizational effectiveness (M = 3.0, SD = 0.9, where 4 indicated strongly agree

and 1 indicated strongly disagree), to interpret guides for assessing organizational capacity for treating CODs such as the DDCAT (M = 3.1, SD = 0.8), and to identify challenges to providing integrated services (M = 3.2, SD = 0.8). Respondents generally agreed that as a result of attending the CODP training, they were better able to use protocol-driven screening methods (M = 3.3, SD = 0.8); to integrate MET, CBT, and TSF (M = 3.3, SD = 0.8); to use CBT for mental health disorders (M = 3.2, SD = 0.8); to examine military-relevant disorders such as PTSD and TBI (M = 3.2, SD = 0.8); and to convey information on issues such as medication compliance and stigma (M = 3.0, SD = 0.8). Figure 5.1 shows the distribution for each item. The program objectives for which there was the most disagreement were "assess organizational effectiveness" and "examine PTSD."

Figure 5.1
Perceptions of CODP Training Achieving Program Objectives (*N* = 36)
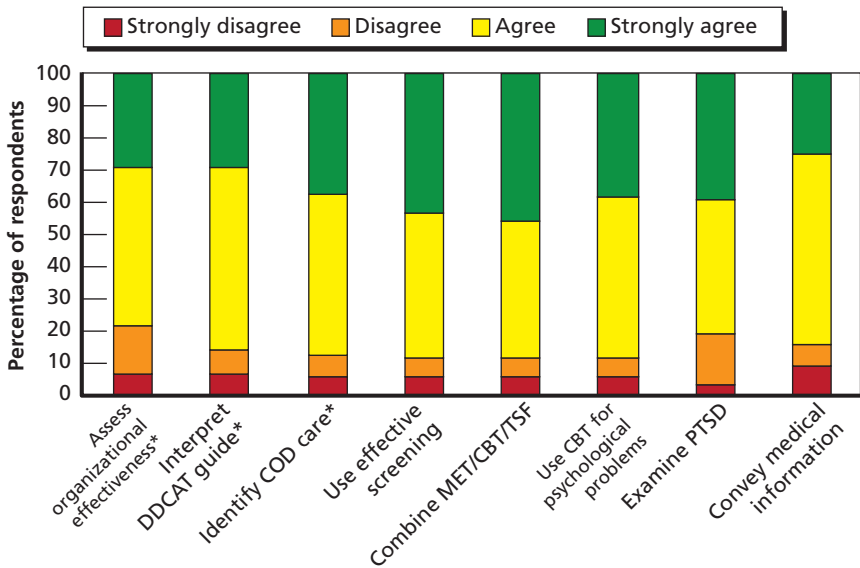
*These items were answered only by the 16 respondents who held administrative positions.

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CODP Trainees Reported that the CODP Met Program and Personal Goals

SARP staff members were asked to talk about ways in which the CODP met its goal "to enhance Navy Alcohol and Other Drug Counselors' ability to assess and treat individuals who have co-occurring disorders." Many SARP staff reported that participation in the CODP training improved their understanding of CODs and how to treat them and that they were able to incorporate at least some of the CODP screening and treatment procedures into their practice. SARP staff reported that the training had its limits. For example, one interviewee noted that the training did not prepare him/her for how to address more severe and rare CODs such as schizophrenia. Another noted that assessment and treatment of individuals with CODs could be improved if trainees had been provided instruction on how to tailor or adapt the training to the population of patients typically seen at their SARPs.

We also asked staff to discuss their personal goals for attending the CODP. Most responded that they hoped to learn more about assessment and treatment of CODs. Some added that they were eager to see how the CODP could be integrated with other programs used at their SARPs, and to provide some relief to the mental health system in addressing mental health needs of post-deployment service members. One interviewee reported very low expectations for the program initially, but was pleasantly surprised by its quality. The majority of interviewees said the CODP did meet their personal goals. Many noted that the program and its materials were explained well, and that they appreciated being provided the materials to use after returning from the training.

Key Informants Believed the Training Was Successful and Met Goals

The Hazelden Program Manager noted that the educational backgrounds of participants in the CODP training varied widely. For example, she said that some had just completed the Navy Drug and Alcohol Counselor School, and others had been practicing for many years, or had master's degrees in social work, counseling, or related mental health fields. Although this might have been a potential obstacle to effective training, this informant said the training was a success. For

example, she said she could not remember anyone saying the training was not worth his/her time. Instead, she observed that everyone left the training "rejuvenated" and "pumped up"; that there was a very "positive energy" around the training. Her impression was that the trainees were excited to return to their SARPs and begin implementing the relevant components of the CODP.

The SARP Director stated that the benefits of the program were "absolutely" worth the costs and that they have already completed additional CODP trainings for newer counselors. He noted that BUMED is limited in its ability to send contract SARP staff to trainings, but that he wishes he were able to send more of them. At some SARPs, a large proportion of counselors are contractors. The SARP Director said he believes the CODP has led to an expansion and enhancement of patient care in the SARPs due to the provision of services for those with CODs, including those with complex problems and who are high risk. He noted that a limitation of the CODP training is that the curriculum uses language tailored for civilian rather than military populations.

Trainees and Key Informants Provided Suggestions for Improving the Effectiveness of the CODP Training

When asked to discuss how the CODP did or did not expand the capability of their SARP to treat clients with CODs, responses from SARP staff interviewees were again mostly positive. Interviewees generally believed they gained knowledge about CODs, their assessment and treatment, and that this helped to better identify and treat these problems. Some limitations were noted as well. For instance, an interviewee reiterated that it would have been helpful to learn how to adapt the program for his/her specific patient population. Several interviewees also stated that while they believe the CODP could substantially improve patient care, lack of confidence and buy-in from SARP administrators, the chain of command, and/or counselors prevented it from expanding their SARP's capability to address CODs. Therefore, they recommended that more of these "key players" attend the training.

SARP staff interviewees had a number of additional suggestions for how to enhance the effectiveness of CODP training. Many said it would be easier to use the skills learned in the training if all staff, including civilian staff, were trained. With regard to content, the following were mentioned as potentially useful additions: increased time for observing practitioners at Hazelden during the training, specific training on how to tailor the program to certain patient populations (e.g., combat exposed, inpatient), and information on how to modify the treatment approaches for brief therapy. Several interviewees also said that more follow-up training and supervision would help to improve fidelity to the program after the training.

When asked what she would do differently if she were to deliver the CODP training to SARP staff again, the Hazelden Program Manager made suggestions consistent with those of the interviewed SARP staff. She recommended that (if funding could be made available) other staff attend (e.g., additional mental health staff). Further, she suggested that to facilitate systemwide understanding and implementation of the CODP, BUMED widely communicate what the CODP is about, the rationale for implementation of the CODP, and that it will be the new standard of care for clients with CODs. The Hazelden Program Manager added that in the future, she would like to add more training on staff support and clinical supervision for the SARP directors. She also reported hearing from several trainees that the Navy's Drug and Alcohol Program Advisors (DAPAs) would benefit from the training. DAPAs inform their commanding officers about substance use within the command and make recommendations about how to address identified substance use problems.

Implementation of the CODP at SARPs Post-Training

In this chapter, we focus on identifying which program elements were implemented and sustained at treatment sites. We include results from the survey of SARP staff members who participated in the CODP training, discussions with SARP staff, and discussions with key informants.

Implementation of the CODP Materials Varied Across Component

Respondents reported that certain CODP materials were used regularly (Figure 6.1). The highest mean level of usage was reported for the ICT binder (M = 2.5, SD = 1.4, with response options ranging from 0 for never to 4 for weekly), and the lowest for the Medication Management binder (M = 1.1, SD = 1.3). Figure 6.2 illustrates respondents' use of CODP supporting materials (i.e., clinician's guide, workbook fact sheets, workbook handouts, and screening/assessment measures). Respondents indicated they used these materials at similar frequencies. The screening/assessment measures were used most often (M = 2.4, SD = 1.4), and the clinician's guide was used least often (M = 1.9, SD = 1.3). Mean frequency of use of screening materials overall (i.e., Screening and Assessment binder, screening/assessment measures) indicated that respondents used these materials a few times a year, on average (M = 2.3, SD=1.4). Respondents reported using the treatment materials (i.e., CBT, ICT binders) with a similar frequency (M = 2.4, SD = 1.4). Overall adoption of the CODP materials was not significantly associated with gender (F(1) = 0.06, *ns*), race/ethnicity (white/non-Hispanic

Figure 6.1
Reported Use of the CODP Materials, Binders (_N_ = 36)
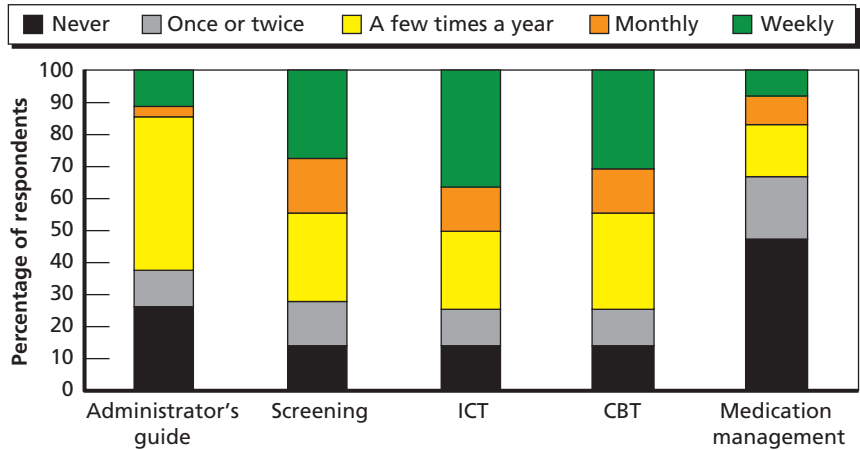
versus other race/ethnicity) (F(1)=1.57, *ns*), or type of SARP position (administrative/clinical or clinical only) (F(1)=0.06, *ns*).

Figure 6.2
Reported Use of CODP Materials, Supporting Materials (_N_ = 36)
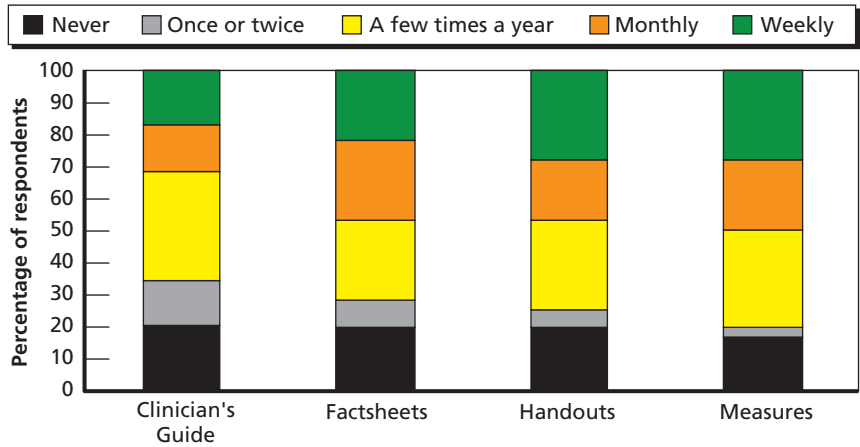
Use of Specific CODP Materials
Administrator's Guidebook

Although only four of the seven interviewees reported being SARP administrators, all were asked about the administrator's guidebook, as others may have held administrative responsibilities in the past. Few interviewees reported implementing the administrator's guidebook. Those who had referenced the guidebook reported that they had looked at it once or twice since the training, as a reference tool. None of the interviewees said they find the guidebook to be very useful. In addition, most SARP staff interviewed had not completed a DDCAT since the CODP training. One had completed the DDCAT after the training and said it was "valuable," but that it "probably needs to be done again."

Screening and Assessment Curriculum

Most interviewees reported that they use parts of the CODP screening and assessment curriculum when they are relevant or applicable to a particular patient or patient population. For example, one interviewee said s/he does not typically use these materials for patients who have already been seen by mental health professionals. One interviewee stated that s/he does not use these materials at all because his/her SARP uses the Navy's existing screening tools, which are "comprehensive." Those who did use the curriculum reported that the materials were helpful for tracking patient progress and for communicating with other providers.

Integrating Combined Therapies Curriculum

Most interviewees were not using the ICT curriculum at the time of their interviews. They indicated that they rely on mental health professionals to provide this type of treatment. Two interviewees said they would like to use it, but that more counselor training and supervision is needed. Another interviewee said s/he had adapted components of the curriculum in designing a treatment program in collaboration with mental health. Only one interviewee had implemented large portions of the ICT curriculum. This individual was using many of the handouts throughout the treatment process, beginning with the first (intake) session. In sum, most interviewees did not feel comfortable using the ICT

curriculum. As suggested by some interviewees, implementation of the ICT curriculum may be improved with additional training.

Cognitive Behavioral Therapy Curriculum

The CBT curriculum was implemented by several, but not all, interviewees. Those who were using the curriculum found it to be useful for issues like depression and anxiety, and for helping patients understand the relationships between their environments, thoughts, feelings, and behaviors. Again, most users were selecting particular portions of the curriculum that they believed fit best for their clients and setting. One interviewee stated that s/he did not use the CBT curriculum because s/he did not want to "overwhelm the patient with paperwork." Those using the curriculum said they felt the materials were clear, logical, and user friendly. One interviewee said s/he appreciated the "ability to move freely throughout the curriculum and only use what is needed."

Medication Management

In general, interviewees did not report using the medication management curriculum on a regular basis. Interviewees generally viewed the medication management curriculum as not relevant for their job responsibilities. Some did not use the curriculum at all, and said this was because another provider was responsible for medication management. Others found the curriculum helpful as a reference guide to understand what patients were taking. Future CODP trainings could modify training on medication management to be in depth for prescribing providers, and simply a general overview for others.

SARP Staff Interviewee Perspectives on the Implementation of the CODP

Most participants in the CODP training completed an "action plan" at the end of the training, where they identified specific actions they planned to take to improve their SARP's dual diagnosis capability within three areas: the intake and assessment phase, the care phase, and the continuing care phase. Interviewees who had completed action

plans were asked about their implementation of the action items they listed in each phase.

Intake and Assessment Phase

Most SARP staff interviewees reported that they had implemented their action items in the intake and assessment phase. Interviewees reported that their SARPs use the CODP screening and assessment tools and procedures but have adapted them for their particular population and setting. For example, one interviewee said, "we incorporated the suggestions from Hazelden that we felt would be applicable to our population." Another said "we integrated parts of the [CODP] screener with other measures from other programs." One interviewee reported that s/he did not implement the screening and assessment tools as planned because of patients' being largely referred from mental health, where they have already had a recent assessment of mental health problems.

Care Phase

Action items listed in the care phase were less consistently implemented. Most interviewees had implemented some, but not all, of their plans. One interviewee said that despite his/her goals, the design and structure of the COD treatment program has been a "work in progress." S/he suggested that because the SARP and the mental health department are working together to design the program, it has sometimes been difficult to decide upon policies that are mutually agreeable. Another said s/he implemented some, but not all, action items, based on what was most useful and necessary. Interviewees noted that some of the things that could make these changes within the care phase sustainable include counselor training and program structure. Specifically, if new counselors are trained in the CODP and current counselors are provided "booster" trainings and supervision, the program is more likely to be sustainable. One interviewee added that his/her SARP was changing in structure, so that it will soon include an inpatient program. This will result in a different patient population and treatment program, which could interfere with the sustainability of the CODP within that SARP.

Continuing Care Phase

A mix of experiences was reported by interviewees when asked about the implementation of their action items relevant to the continuing care phase. One interviewee reported that s/he was unable to implement these items because the "command was not on board." Others indicated that they were able to implement their action items, after adapting the CODP materials and curriculum to work with their patients and system of care.

Key-Informant Perspectives Were Similar to SARP Staff Perspectives

The Hazelden Program Manager indicated that she has received feedback primarily from the larger SARPs since delivery of the CODP trainings. She reported implementation of the CODP has varied depending on each SARP's level of care. For example, she said some SARPs provide screening and continuing care, but not treatment. She added that most SARPs do not provide medication management. Therefore, there are likely to be particular portions of the CODP that are more or less relevant depending on the SARP. The Hazelden Program Manager said, from the feedback she has received, the counselors who attended the training are "doing integrated treatment to the best of their ability." She noted that they have taken the tools and adapted them for their clients. The Hazelden Program Manager acknowledged that the family component of the CODP has not been implemented because few SARPs provide family programs.

Consistent with the Hazelden Program Manager's report, the SARP Director also believed the CODP materials and training were being implemented and perceived as useful by SARP staff. He noted that use of the materials likely varied depending on staff motivation. The SARP Director reported that he did not have any formal mechanism for monitoring SARP staff implementation of the CODP.

Facilitators and Barriers to CODP Implementation

In this chapter, we identify facilitators and barriers to successful implementation of the CODP. In addition to understanding overall levels of implementation of the CODP materials, we sought to understand *why* the CODP, and particular components of it, were more or less likely to be implemented than others. We include results from the survey of SARP staff members who participated in the CODP training, discussions with SARP staff, discussions with key informants, and the site visits.

Several Factors Facilitated Adoption of CODP Materials

Survey respondents generally agreed that the CODP materials were useful and of high quality (Workshop Assessment Quality and Utilization score: M = 41.9 [possible scale range 10–50], SD = 7.1). In addition, respondents believed their SARPs provide sufficient staffing, resources, and time, and that SARP counselors have adequate training and have implemented the materials effectively (Workshop Assessment Resources and Skills score: M = 41.3 [possible scale range 10–50], SD = 11.6). On average, respondents also felt that their SARP directors, supervisors, and fellow staff supported and encouraged one another to use the CODP materials (Workshop Assessment Support and Commitment score: M = 37.0 [possible scale range 10–50], SD = 8.1).

In our analysis of the web survey data, we sought to identify factors associated with higher adoption of CODP materials. In addition to overall adoption of CODP materials, we also evaluated factors

associated with use of CODP screening and assessment materials and CODP therapy materials. These two subscales were highly correlated ($r = 0.58$) but still suggested that evaluating these portions of CODP use separately was warranted. We examined the associations between CODP adoption and barriers and facilitators and attitudinal measures (Table 7.1). Higher overall adoption of CODP materials and CODP therapy materials use was significantly associated with higher scores on several scales measuring facilitators of adoption (e.g., beliefs that the CODP training was of high quality and useful, feeling that colleagues and supervisors are supportive and committed to the use of the CODP). A similar pattern was observed for CODP screening use. Higher overall use of the CODP materials and use of CODP therapy materials were also significantly associated with lower levels of barriers. Use of screening materials was not significantly associated with barriers. Only one significant correlation was observed between attitudes variables (EBPs, patients with mental health and substance use disorders) and use of CODP materials. Specifically, those who used the CODP more frequently overall also expressed higher openness to using EBPs.

Increased Supervision Facilitated Implementation of the CODP

Over one-half (55 percent, $n = 20$) of survey respondents reported that they had received clinical supervision to help them implement the CODP after the training. They reported receiving a variety of modalities of supervision: in-person or telephone meetings with supervisor ($N = 13$), peer consultation ($N = 11$), live observation ($N = 10$), supervisor watching video-recorded sessions ($N = 5$), and group training ($N = 1$). No respondents reported that a supervisor listened to audio-recorded sessions. Nine respondents said they had received over 20 supervision sessions since the training; four reported receiving six to 20 supervision sessions; and seven respondents said they had received five or fewer supervision sessions. The number of other trainings on CODs ranged from zero to 12 (M = 2.1, SD = 2.5). A greater number of supervision sessions was significantly correlated with more-frequent use of the CODP materials overall ($r = 0.70$, $p < 0.01$) and the CODP therapy materials ($r = 0.59$, $p < 0.01$), but not with CODP screening

Table 7.1
Correlates of Adoption of the CODP Materials (*N* = 36)

	CODP use (total)	CODP use: screening	Quality/utilization	Resources/skills	Support/commitment	Barriers	Any supervision	Number of supervision sessions	Any COD trainings	Requirements	Appeal	Openness	Divergence	EBPs attitudes	Attitudes toward COD	Nonmoralism	Treatment optimism	Nonstereotypes	Treatment intervention	Permissiveness
CODP use (total)	1.00		0.62**	0.40*	0.59**	-0.58**	0.20	0.70**	0.14	0.12	0.13	0.36*	0.18	0.19	0.03	-0.17	0.22	0.05	0.07	-0.20
CODP use: Screening	0.74**	1.00	0.40*	0.10	0.42*	-0.20	0.46**	0.33	0.26	-0.02	-0.10	0.03	0.21	-0.14	0.33	-0.09	-0.09	0.16	-0.16	0.04
CODP use: Therapy	0.86**	0.58**	0.44**	0.45**	0.57**	-0.50**	0.23	0.59**	0.18	0.17	0.07	0.27	0.12	0.14	-0.10	-0.10	0.27	0.01	0.01	-0.23

* *p* < 0.05

** *p* < 0.01

materials. Interestingly, adoption of the CODP materials overall or the therapy materials was not significantly associated with whether supervision was received, but use of the CODP screening materials was significantly correlated ($r = 0.46$, $p < 0.01$). Participation in additional trainings on treatment of CODs was not significantly correlated with use of these materials.

Organizational Characteristics Were an Important Factor in Successful Implementation

In the interviews with SARP staff, the most commonly noted facilitators and barriers were related to the level of support for the program from the chain of command and fellow staff. For example, several interviewees noted that having their staff "on the same page" and trained in the program had facilitated implementation. Conversely, other interviewees who experienced a "lack of buy-in" from the chain of command and other staff, or where the chain of command and other staff had not received training, found this to be a major barrier to implementation. Other organizational barriers included inadequate resources (e.g., time, funding, supplies) and difficulty collaborating with the mental health department.

The Hazelden Program Manager echoed statements made by SARP staff, highlighting "synergy with the mental health component of their [SARP] treatment services" and support from SARP directors and supervisors as key factors that could help or hinder implementation. She said that when SARPs had established working relationships with mental health, implementation was more likely to be successful. On the other hand, SARPs without strong relationships with mental health, or where mental health resources may not even be readily available, had more difficulty implementing the CODP. The SARP Director said he had not observed that SARP relationships with mental health play a key role in implementation.

The Hazelden Program Manager also noted that inadequate support from SARP directors and a lack of clinical supervision served as barriers to implementation. She reported that when SARP directors were not in support of the program, counselors felt as though they did not have to use the CODP. The SARP Director also articulated this

view in his interview. On the other hand, when SARP directors had been trained in the CODP and were supportive of the program, both the SARP Director and the Hazelden Program Manager reported, implementation occurred much more easily. The SARP Director observed that resistance from SARP staff similarly hindered implementation. He said he believed sending more staff to the trainings would aid implementation.

Most Trainees Reported the CODP Materials Facilitated Implementation, but Some Reported Needing Additional Implementation Support

Some interviewees also reported that the lack of specific training on how to implement the program at their particular site with its patient population made it difficult to use the CODP. On the other hand, most interviewees reported that the design of the CODP made it easy to incorporate the training into existing SARP procedures. Many added that the training's instruction on the CBT modules and about CODs in general were particularly helpful for knowing how to effectively implement the CODP.

Barriers to SARP Implementation of CODP Training

Barriers to Implementation Were Not Frequently Endorsed by Survey Respondents

On average, survey respondents did not report barriers to using the materials, as illustrated by average scores indicating disagreement with statements about barriers (e.g., not using the materials because of a lack of time, not feeling well trained, disagreeing with the philosophy of the CODP; Workshop Assessment Barriers Encountered score: M = 21.5 [possible scale range 10–50], SD = 7.1).

Respondents were "moderately" willing to adopt new EBPs (total EBPs attitudes scale: M = 1.9, SD = 0.3, with response options ranging from 0 for "not at all" to 4 for "to a very great extent"). Subscale scores further suggest that respondents are not resistant to the use of EBPs. Respondents indicated they would be moderately likely to adopt

a new method for delivering treatment if required by their supervisor or the Navy (Requirements: M = 2.0, SD = 0.6). Staff also believed they would be more likely to use a new training if it appealed to them (e.g., it makes sense, colleagues are happy using it) (Appeal: M = 3.0, SD = 0.8). Respondents were also open to trying new types of interventions (Openness: M = 2.8, SD = 0.8). Respondents expressed very little resistance to using research-based or manualized treatments (Divergence: M = 0.9, SD = 0.6).

Respondents did not endorse negative beliefs about clients with co-occurring mental health problems (Clinician Attitudes Questionnaire: M = 1.5, SD = 0.6, with response options ranging from 1 for "strongly disagree" to 5 for "strongly agree"), and there was little evidence for negative attitudes toward clients with SUDs. SARP staff disagreed with negative moral judgments about clients with SUDs (e.g., addiction is associated with weak will) (Nonmoralism: M = 2.0, SD = 0.7, with response options ranging from 1 for "strongly disagree" to 5 for "strongly agree"). This is consistent with respondents' disagreement with negative and general statements about clients with SUDs, such as "heroin is so addicting that no one can really recover once s/he becomes an addict" (Nonstereotypes: M = 1.8, SD = 0.6). Respondents also disagreed with permissive views of substance use (e.g., "daily use of one marijuana cigarette is not necessarily harmful") (Permissiveness: M = 2.0, SD = 0.6). Overall, respondents had optimistic views of the treatability of SUDs (Treatment Optimism subscale: M = 4.5, SD = 0.5). They also appear to believe certain aspects or types of intervention (e.g., group therapy) to be important in treatment of addiction (Treatment Intervention: M = 4.0, SD = 0.5.

Site Visits Suggested That Staff Reluctance, Lack of Trained Staff, Low Perceived Need for COD Services, and Low Actual Need for COD Services Were Key Barriers

At the time of our visit, Site A[1] had a specific program for clients with CODs, where the CODP video and CODP CBT materials were rou-

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[1]   Site A: Self-rated low CODP adopters, no web survey DDCAT; 2,205 clients screened in 2011.

tinely implemented. In the COD program, clients watch the introductory video in week 1, and seven hour-long CBT sessions from the CODP are conducted over the course of the next three weeks. The intervention is delivered in a group setting by a psychologist. However, staff at this site indicated that outside of these CBT groups, the CODP is not consistently implemented in treatment for clients with CODs. The site identified two primary barriers to CODP implementation: (1) lack of trained staff and (2) staff reluctance. Site A SARP staff said that due to the stipulations of the Navy's contract with Hazelden, many of their civilian contracted counselors were unable to attend the CODP training. The site was in the process of scheduling on-site CODP trainings that would be offered to all SARP staff in order to address this. The second major barrier noted by SARP staff was the reluctance of some counselors to implement the CODP or other treatments targeting CODs. Site A staff observed that SARP providers with formal mental health training, such as psychologists, were generally implementing the CODP in their practice, but that the majority of staff, who do not have such training, resisted using the program. SARP staff and administrators noted that although many substance abuse counselors receive some consultation from psychologists who encourage the implementation of the CODP for clients with CODs, most SARP counselors seem to prefer using other techniques to focus primarily on SUDs. This suggests that staff reluctance could be related to lack of training, concerns about practicing outside a scope of practice that has traditionally focused only on substance use issues, or not seeing the need for an alternative treatment approach. SARP administrators indicated that hiring more staff with expertise in evidence-based treatment of CODs, training all SARP staff in the CODP, and offering CODP supervision following the training could address these barriers and improve implementation at the site.

Site C[2], much smaller than Site A, did not have a specific program for clients with CODs at the time of our visit. SARP administrators at Site C estimated that approximately 20 percent of their cli-

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[2] Site C: Self-rated low CODP adopters, Addiction Only Services; 295 clients screened in 2011.

ents have CODs. Counselors reported providing treatment for CODs on an as-needed basis. Site C staff indicated that in such cases, they often use materials from Hazelden's "Living in Balance" (LIB) curriculum rather than from the CODP. LIB is a group-oriented program that focuses primarily on substance abuse but includes sessions related to anger, negative emotions, and stress. We learned that clients also attend "lectures" focused on specific topics, which are sometimes related to CODs (e.g., "stress and emotions") or use theoretical frameworks consistent with the CODP (e.g., cognitive behavioral), but that do not specifically include CODP materials or content. Key barriers to implementing the CODP at this site included (1) staff reluctance and (2) low perceived need for COD treatment. Similar to Site A, at Site C it appeared that although staff had received CODP training, they seemed to prefer other treatment curricula, such as the LIB curriculum. Group therapy was reported to utilize supportive counseling, twelve-step, and LIB techniques. While some clients also received individual treatment, where CODs might be more commonly addressed, the CODP was not reported to be implemented in these settings either. This may reflect reluctance or ambivalence on the part of counselors as well as SARP leadership. Implementation of the CODP was not being monitored by SARP administration at this site. Staff also said it was relatively uncommon for their clients to present with CODs. Therefore, there may have been limited opportunity to implement the CODP at this site. However, as described later (see Figure 8.1), there is room for improvement in the assessment of CODs at Site C.

SARP Site D[3] was the smallest we visited. Administrators reported seeing only approximately five service member clients at one time, along with approximately two dependents (e.g., spouses of service members). We learned that most clients (70 percent), who do not meet DSM-IV criteria for substance abuse or dependence, go through a brief video-based educational program and are then discharged. Approximately 30 percent receive additional treatment, usually individual therapy. SARP counselors reported implementing the CODP materials in individual

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[3] Site D: Self-rated high CODP adopters, Dual Diagnosis Capable; 61 clients screened in 2011.

therapy sessions with clients with CODs, although their doctoral-level supervisor had not been trained in the CODP and seemed not to have heard of the program. While there appeared to be a great deal of counselor enthusiasm for the CODP at Site D, the primary barrier to its implementation seemed to be the small number of clients at the site.

SARP Capability to Provide Integrated Care for Co-Occurring Disorders

In this chapter, we describe the degree to which Navy SARPs are capable to provide integrated care for CODs. We include results from the survey of SARP staff members who participated in the CODP training and the site visits. The level of integrated care provided at SARPs was assessed using the DDCAT. The DDCAT was completed via self-report on the survey for those who identified themselves as serving in an administrative role within their SARP (N = 16). Two of the 16 DDCAT respondents came from the same SARP. Therefore, the DDCAT findings from the web survey represent 15 different SARPs. The DDCAT was also completed by trained observers during site visits. It is important to first note that the DDCAT is a measure of a site's *capability* to provide integrated treatment for clients with CODs. It is not a measure of the quality of care provided, nor of the use of the CODP materials specifically. However, it does offer useful information about whether the physical, organizational, programmatic, and staffing infrastructures necessary for effective implementation of the CODP are in place.

As described in Chapter Three and in Appendix A, the DDCAT is scored across subscales to provide an assessment of the extent to which sites are able to provide COD treatment. The results of the analysis are presented by describing whether a site falls into one of three categories (McGovern et al., 2010):

- Addiction Only Services: Site focused on providing services for clients with SUDs, but not for those with co-occurring psychological health disorders.

- Dual Diagnosis Capable: Site is able to provide services for some clients with CODs but has higher capacity for those with SUDs.
- Dual Diagnosis Enhanced: Site can provide services for any client with a COD. The site can fully and equally address both substance use and psychological health disorders.

Over One-Half of Survey Respondents Reported Their SARP Capable of Providing Addiction Only Services

Over one-half (56 percent, $N = 9$ of 16 administrators) rated their SARP as providing Addiction Only Services. Self-report ratings by administrators at these sites indicated that their SARP is not equipped to treat clients with CODs. Seven rated their SARP as Dual Diagnosis Capable. No respondent rated his/her SARP as Dual Diagnosis Enhanced. Because it is possible that self-reported DDCAT scores are confounded by the amount of DDCAT training received or with exposure to and training in the CODP, we explored whether DDCAT ratings were related to the amount of CODP supervision and other training in treatment of COD that respondents had received. Theoretically, individuals with more DDCAT training, or with more knowledge about CODs and integrated treatment for them, might rate their SARPs differently compared to those with less training in these areas. However, we found that DDCAT ratings did not significantly differ based on the number of CODP supervision sessions received ($F(1) = 0.6$, *ns*) or in the number of other trainings on CODs ($F(1) = 1.8$, *ns*). Self-report assessments of capability of providing care for clients with CODs using the DDCAT have limitations, as self-reports tend to be higher than objective observer scores. Yet it is notable that over one-half of respondents reported their SARP was capable of providing only addiction services, and that no respondent rated his or her SARP in the highest category (Dual Diagnosis Enhanced).

Site Visits Identified Variability in Capability to Provide Integrated Care for CODs

The overall DDCAT scores from the three sites are shown below in Table 8.1 (please refer to Substance Abuse and Mental Health Services Administration [2011] for the full list of DDCAT items within each domain). A score of 5 indicates the site is Dual Diagnosis Enhanced, a 3 is Dual Diagnosis Capable, and a 1 is Addiction Only Services. Site A's DDCAT score of 3.26 indicates that the site was rated to be capable of providing dual diagnosis services overall. The other two sites' scores (2.16 and 2.37) suggest they are capable to provide Addiction Only Services, and capable to provide dual diagnosis services in some but not all areas. Table 8.1 shows the overall DDCAT score and dual diagnosis capability for each site.

Figure 8.1 displays the three sites' DDCAT scores on each domain, which provide some insight into relative strengths and weaknesses. For example, DDCAT scores are highest on training at the sites, indicating that this is a relative strength, whereas dual diagnosis treatment is among the lowest scores at each site, suggesting it is a relative weakness.

Site A had the highest DDCAT scores among the SARPs we visited. Site A scored in the Dual Diagnosis Capable range on program structure and program milieu because the SARP has a formalized collaboration with mental health clinics on site, and it openly displays and distributes materials related to COD assessment and treatment. The SARP at Site A demonstrated that clinicians expect to see CODs and efforts are made to prepare clinicians to be able to treat mental health disorders along with SUDs, or to refer them to partnering mental health clinics. Site A was also Dual Diagnosis Capable in assessment of

Table 8.1
Dual Diagnosis Capability, by Site (*N* = 3)

Site	Overall DDCAT Score	Overall Dual Diagnosis Capability
A	3.26	Dual Diagnosis Capable
C	2.16	Addiction Only Services/Dual Diagnosis Capable
D	2.37	Addiction Only Services/Dual Diagnosis Capable

Figure 8.1
Dual Diagnosis Capability Scores, by Domain
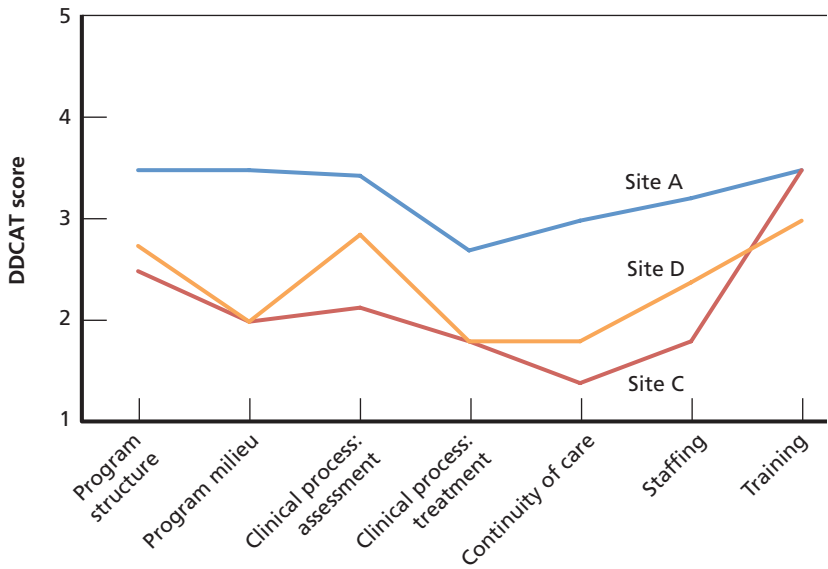
NOTE: 1 = Addiction Only Services, 3 = Dual Diagnosis Capable, 5 = Dual Diagnosis
Enhanced.
RAND *RR435-8.1*

CODs due to evidence that staff routinely screened for mental health symptoms and typically conducted more formal mental health assessments when indicated. Psychiatric diagnoses were often recorded in client charts, and the program was prepared to accept patients with moderately severe mental health problems. Their score on treatment was lower, but approached the Dual Diagnosis Capable range. Site A's SARP appeared to address substance use as the primary disorder and addressed mental health disorders secondarily. There was variability in the extent to which clinicians reported on the progress of mental health problems and stages and motivation to change among SARP clients. More consistency among clinicians' reports would help to improve this site's DDCAT treatment score. Another strength of this program, however, was the implementation of evidence-based programs for mental health and substance use problems, such as the CODP, particularly

among psychologists at the SARP. There was less consistent use of evidence-based COD treatment among alcohol and drug counselors, however, although most counselors had attended the CODP training. Site visit data from Site A also suggested that the SARP made an effort to consider CODs in continuity of care planning. Although there was not a formalized protocol to manage mental health needs after departure from the SARP, data indicated that most clinicians provided care until the client could begin receiving care elsewhere. Peer support groups for CODs (e.g., "Double Trouble") were reported to be lacking in the community around Site A, and staff indicated it was difficult to connect clients with CODs to such groups because of this. Staffing and training were also strengths at Site A, where a psychiatrist worked full time and on site for the SARP. On-site supervision from psychologists was also available for counselors as needed, and case reviews were regularly conducted and included discussion of CODs. The primary weakness in staffing at Site A was that less than one-quarter of staff held a mental health licensure (doctoral or master's level) or similar competency. However, most direct care staff had at least some basic training in how to recognize and screen for mental health symptoms, and the majority had also received training in treatment of CODs via the CODP.

Site C had lower DDCAT scores on every dimension except training, where most staff had received CODP training. Site C scored lowest on continuity of care. Administrators at this site indicated that because their clients come from and are discharged to a variety of geographical areas that may not be close to the SARP, it is difficult to coordinate treatment for CODs following treatment at the SARP. In addition, however, the site did not appear to focus on recovery issues for mental health disorders. Instead, most continuity of care planning revolved around SUDs. Clients at the SARP at Site C had limited access to prescribers. This SARP had no formal relationship with a prescriber, which contributed to its low DDCAT staffing score. Less than one-quarter of staff had mental health licensure or similar competency, but these staff did provide on-site consultation and supervision for other staff as needed. Case reviews did not regularly cover CODs, and peer/

alumni supports for CODs were not available. These factors also contributed to the lower staffing score.

Site D had similar DDCAT scores to Site C, except on assessment, where Site D scored in the Dual Diagnosis Capable range. Site D sometimes collected mental health histories but routinely screened for mental health disorders using standardized instruments with established psychometric properties. Clients who screened positive on these measures were sometimes, but not routinely, assessed more formally. In cases with positive screens, mental health diagnoses were usually documented. Site D admitted people with moderately severe mental health symptoms, as long as they were stable, whereas Site C indicated it was unable to accept clients with more than low severity and persistence of mental health problems. Site D also had a consulting psychiatrist on site, and clinicians regularly met with a licensed, supervising psychiatrist to discuss cases as well. The involvement of these mental health staff contributed to the near–Dual Diagnosis Capable score on staffing.

In the next chapter, we provide a summary of findings, along with recommendations for improving clinician training and treatment delivery for CODs.

Summary and Recommendations

This evaluation had two main aims: (1) to understand the CODP training approach and program goals and (2) to describe the implementation of the CODP, including trainee perceptions of the training, implementation of specific program elements, facilitators and barriers to successful implementation of the CODP, and programs' capability to provide integrated care. This chapter summarizes the key findings from the evaluation and describes limitations that should be considered in interpreting our results. Finally, we offer suggestions for improving future CODs clinician training efforts and improving care for CODs.

Summary of Findings

CODP Training Approach and Program Goals

The Hazelden Co-Occurring Disorders Clinician Training Program is an evidence-based program that uses an integrated approach to treat clients with co-occurring psychological health and substance use disorders. Between 2008 and 2010, approximately 226 Navy clinician trainees received CODP materials and attended an offsite training ranging from five to seven days at Hazelden in Center City, Minnesota. Key-informant interviews indicated that the Navy's goal for the CODP training was to provide SARP staff with an evidence-based approach to delivering integrated treatment for CODs. The Navy supported this approach by sending SARP staff from a range of military installations to receive training at Hazelden.

Implementation of the CODP

Based on findings from the survey, as well as from interviews with trainees and key informants, trainees were generally positive about the CODP training and materials. For example, web survey respondents reported the training left them feeling confident about their ability to implement the CODP materials at their SARP. Interviewed trainees agreed that the training met or exceeded their personal expectations. Interviewees also noted areas where the training could be improved. These included a need for refresher trainings and CODP supervision post-training; insufficient information on how to tailor the program for specific patient populations (e.g., high combat exposure, severe mental illness); the need for all staff, including civilians, administrators, and leaders to receive some training in the program in order to increase buy-in and support for the CODP; a desire for more time observing Hazelden practitioners implementing the CODP during the training; and information on how to modify the CODP for shorter-term treatment.

Findings from the survey and interviews suggested that the screening and assessment materials, as well as portions of the CBT and ICT curricula, were used most frequently following the training, while the administrator's guide and medication management materials were used least frequently. The administrators we spoke with suggested refresher trainings on how to use the DDCAT would have helped them to sustain use of the measure. In general, participants indicated that they generally did not implement the entire CODP but instead selected the pieces they felt were most useful and tailored the materials for their clients' needs. Interviewees expressed interest in receiving clear direction and guidance from leadership as to how broadly and thoroughly the CODP should be implemented. Some said they believed it would be helpful if implementation of the materials were standardized, to the extent possible, across SARPs. Thus, while most study participants reported feeling satisfied with the CODP training, few were fully implementing the CODP in their clinical practice.

Facilitators and Barriers to Successful Implementation

Overall, data from all sources indicated several factors helped them to implement the CODP in practice. This included the high utility and quality of the CODP materials, having sufficient staffing, supervision, resources, and time to implement the program, and having SARP counselors with adequate training. Participants noted that encouragement from SARP directors, supervisors, and fellow staff to use the materials facilitated implementation as well. Participants generally were willing to adopt new EBPs and did not hold negative attitudes toward clients with mental health or substance use disorders. However, these attitudes were not found to be related to implementation of the CODP, except that those with more openness toward EBPs used the CODP more frequently. Interviewed SARP staff added that support from the chain of command was an important facilitator of implementation, as was the CODP's instruction on the CBT modules and about CODs. They noted that difficulty collaborating with mental health clinics could be a barrier to implementation. Data from the site visits further suggested that SARPs with a low perceived need for the CODP, due to having a small number of clients with CODs or in general, led to a weaker effort to implement the program.

The Level of Integrated Care Provided in the Programs

In general, most of the SARPs for which we obtained DDCAT ratings (i.e., via web survey or site visits) did not appear to be providing integrated care for CODs. Over one-half of survey respondents rated their SARP as providing Addiction Only Services, and data from the site visits were consistent with this finding: Of the three SARPs we visited, one was rated as Dual Diagnosis Capable, and the other two as Addiction Only Services. The facilitators and barriers to implementation described above were also associated with SARPs' capacity to provide integrated care.

Limitations

It should be noted that this evaluation has some limitations that should be considered when interpreting the results. First, the evaluation was initiated approximately two years after the completion of the last round of clinician trainings. While this post hoc evaluation still holds value, the evaluation design could be stronger if planned in advance of the training program. For example, we were not able to incorporate pre-training and posttraining clinician assessments with validated measures, limiting our ability to assess change in clinician skill over time. In addition, we were unable to monitor clinician implementation of the training materials immediately after attending the training. Future DoD clinician training efforts would be strengthened by incorporating a rigorous evaluation plan prior to initiating the training program. This could also incorporate assessment of patient outcomes before and after training. However, the timing of this data collection was also a strength of the study. Implementation of a new treatment program takes time and often requires organizational changes that can be slow moving. By assessing implementation two or more years following the training, this study provides information about the broader, longer-term processes associated with the implementation of the CODP training.

Second, we note limitations from the size and representativeness of our clinician sample. We limited the survey and interview sample to trainees with active duty, reserve, or retired military status. Due to regulatory issues, we were not able to incorporate the perspectives of civilian trainees who were not retired military or spouses of military personnel (approximately 14 percent of trainees, according to data obtained from Hazelden). In addition, nearly 40 percent of trainees did not receive the invitation to participate due to inaccurate contact information. This highlights the challenges of conducting the evaluation several months after the completion of the training program. It also highlights the high rate of staff turnover among trainees. We obtained an adjusted response rate of 32 percent. While this response rate is not unusual for a clinician survey, it should be noted that this represents only 16 percent of all trainees. Therefore, the resulting sample may be biased toward clinicians who were using the CODP materials more

frequently or who were more engaged or motivated to treat CODs. These factors contributed to a small sample size, limiting our ability to conduct more sophisticated multivariate analyses.

Third, the data collected for this evaluation relied largely on clinician self-report on their perspectives of the training and use of the CODP materials. Due to social desirability factors, clinicians may be more likely to report favorable attitudes and increased use of the CODP materials that may not accurately reflect clinical practice. Also, clinicians received training in these materials but may not have reached competence in using the materials. Varying levels of familiarity and competence in using the materials could have biased their reports. We were not able to observe or record treatment sessions and conduct structured coding of the degree to which sessions adhered to the CODP treatment materials. These objective assessments of fidelity and competence would have supplemented the clinician self-report information. Nonetheless, clinician perspectives still provide valuable insight on the utility of training and subsequent implementation.

Finally, we note that we conducted site visits at only three Navy SARPs. Individual SARPs vary in many ways (e.g., size, resources, staffing mix) that could affect the generalizability of the site visit results. While we aimed to select a diverse mix of SARPs for the site visits, three SARPs simply cannot represent the diversity in individual SARP sites. Still, these site visits provided rich, detailed information regarding what may contribute to increased implementation of the CODP materials and improved care for CODs. Despite these limitations, we believe the integration of multiple data sources, both quantitative and qualitative, provides key insights in the potential value of the CODP training program.

Recommendations

In this section, we draw on key findings from the evaluation to provide recommendations in how to improve future efforts to train clinicians in treating CODs. While this evaluation focused on the CODP, our recommendations are intended to apply to the treatment of CODs

within the military health system more generally. It was outside the scope of the evaluation to make recommendations about the future of the CODP, as the evaluation focused on implementation of the program rather than its effectiveness. Rather, these recommendations can be used to inform the development of and future investments in programs like the CODP that aim to improve the delivery of integrated care for service members with CODs.

Recommendations to Improve Implementation of Clinician Training Programs

Investing in clinician training in evidence-based screening and treatment approaches demonstrates a commitment to improving care for service members. Given the significant investment involved (e.g., training funds, clinician leave time), it is essential that training efforts demonstrate a return on this investment. Research suggests that program implementation is most successful when there is sustained support for the program at multiple levels (e.g., SARPs, installations, BUMED, the Navy) and in multiple domains (e.g., financial, policies, treatment and training materials, staffing, supervision) (Bachman and Duckworth, 2003; Fixsen et al., 2005; Klein and Sorra, 1996; Powell et al., 2012; Rodgers, Hunter, and Rogers, 1993; Rogers, 1995; Simpson, 2002). We highlight how future training efforts could be improved at different levels and areas over time. Our recommendations cut across several phases of the implementation process, ranging from selecting and planning for training, to the training delivery, and supporting implementation of training materials following the training.

Recommendation 1. Develop a training plan that specifies how the training will be implemented and sustained, obtain leadership support, plan for staff turnover, provide consultation after training, and evaluate training efforts.

Recommendation 1a. Select a clinician training program that provides ongoing consultation and implementation support.

When selecting a clinician training, it is essential to ensure the content is appropriate and relevant for the targeted clinicians. Training programs that provide ongoing consultation and implementation support are more desirable, as it is not unusual for clinicians to attend a

didactic workshop training and not reach competence in delivering an intervention (Beidas and Kendall, 2010; Miller et al., 2004; Sholomskas et al., 2005).

Recommendation 1b. Obtain organizational support from leadership prior to initiating training.

Developing a plan prior to initiating the training program could also increase the impact of the training. This planning should include obtaining buy-in from leadership, both at the clinic and base command levels. SARP administrators were invited to attend the training, which can facilitate engagement and support of the treatment. Yet attendance was optional, so not all SARP administrators attended. Administrators may benefit more from a training designed specifically for their needs. Further, providing options for training mode (e.g., online versus in person) may increase participation. An administrator training could be shorter and could focus on providing an overview of the treatment program and its benefits, and how to ensure quality implementation of the program rather than specific techniques to deliver the treatment. Then SARP administrators would be trained to serve as "local leaders" who could identify an implementation plan that is appropriate for their site (e.g., which components to implement, which staff implements each component), encourage use of materials, and problem solve as necessary. They can also assist in ongoing monitoring of the implementation.

Recommendation 1c. Develop a consistent approach to training relevant staff and strategies to address future staff turnover.

The plan should also address which staff should be trained and include an active plan to address staff turnover and reassignments. For the CODP training, contractors were not trained because they could not travel to the training. On-site or online training methods would help to ensure that contractors, who often stay at a particular site for longer periods than active duty clinicians, receive training as well. Staff turnover is routine; therefore, clinician training must be responsive to this. Lengthy offsite training, which tends to be higher-cost due to travel and time away, may not be the most appropriate approach for staff who may be reassigned to a new position in three years. Navy SARPs may want to consider using a train-the-trainer model (Martino et al., 2011) in which one or two SARP staff are selected and trained

as experts, who are then available to provide training to other staff at their site. Navy SARPs may want to select civilian staff (contractors or government employees) as the first trained, as they may have a longer tenure at a particular site than active duty counselors. This may help to increase the long-term value of the training investment. If contractor or civilian government employee staff members are not able to travel to receive training, it is important to identify other approaches to training (e.g., online training, remote supervision).

Recommendation 1d. Provide consultation following the training.

The likelihood of successful implementation would be increased if trainees received ongoing consultation or supervision to reach competence. While a didactic training may be enough to support integrating validated screening tools, a didactic training is not enough to reach competence in delivering an evidence-based psychotherapy (Sholomskas et al., 2005). Consultation or supervision following didactic training is required to reach competence and should be integrated into any future training effort.

Recommendation 1e. Develop an evaluation plan to support assessing the success of the training.

Finally, as mentioned earlier, it is essential to develop a plan in advance to evaluate the training effort.

Recommendation 2. Ensure clinician trainings focus on materials and skills that are most relevant to the site's clinical practice.

This evaluation suggested that the training provided by Hazelden was well received. Future trainings could be improved by focusing on particular components of the materials that have the best evidence base and are most relevant to the site's clinical practice. The CODP program materials are comprehensive, yet it was clear that some materials were used frequently (e.g., Screening and Assessment, Cognitive Behavioral Therapy, Integrating Combined Therapies) and some materials were used rarely (e.g., Medication Management, Family Program). For example, SARP staffers rarely integrate family members into treatment, so the Family Program component was not as relevant to their practice. Given staff turnover and challenges in reaching competence in new clinical skills, less breadth and more focus would increase

the likelihood that clinicians would be able to use the new materials effectively.

Recommendations to Improve Treatment for Co-Occurring Disorders Within the Military Health System

The goal of the CODP program was to improve care for service members with co-occurring disorders. Next, we provide some considerations for how care for COD delivered in the MHS could be improved. These considerations incorporate findings from this evaluation and the literature on improving care for co-occurring disorders.

Recommendation 3. Consider requiring that all service members who receive care from a SARP be screened for psychological health problems using validated measures.

Screening measures should be used to identify common co-occurring psychological health conditions such as depression (e.g., PHQ-9 [Patient Health Questionnaire]; Spitzer, Kroenke, and Williams, 1999), anxiety (e.g., GAD-7 [Generalized Anxiety Disorder 7-item scale]; Spitzer et al., 2006), and PTSD (e.g., PC-PTSD [Primary Care Posttraumatic Stress Disorder Screen], Prins et al., 2003). Discussions with staff (by phone and during site visits) suggested that SARP staff may not routinely identify clients with CODs. Routine screening of service members who enter formal treatment, and those who receive less-intensive interventions (e.g., education following a DUI), would provide a mechanism to systematically identify these clients. Routine screening would also help SARP staff understand the prevalence of CODs and need to effectively treat these clients.

Recommendation 4. Identify and certify select sites as providing enhanced services for service members with CODs, rather than assuming that all SARPs can provide high-quality care for CODs.

We observed variability across SARPs in terms of their capability to provide evidence-based care for CODs. There is still a need to improve the quality of care to service members with CODs. For example, 30 percent of staff indicated their site had a specialized COD program, and one-half of respondents indicated their SARP as only capable of providing addiction services. Only 36 percent of respon-

dents indicated they offered medication-assisted therapy, a significant limitation given the recent review confirming the effectiveness of psychotropic medications for alcohol (Jonas et al., 2014), and only 31 percent offered psychiatric medication, a first-line treatment option for several psychiatric disorders. Some sites may see a very small number of clients, and it may not be the best use of resources to provide specialized treatment for CODs at every site. An alternative to attempting to train all staff at all SARPs to deliver COD care is to identify particular sites that have the capability to provide evidence-based care for CODs and ensure that service members with CODs get care at those sites. This may involve transferring a service member to another base to get treatment, but we observed this occurring regularly. Individual SARPs could be reviewed and certified as COD programs using a structured site visit tool like the DDCAT. Repeated on-site DDCAT assessments by a trained, objective rater also provide ongoing feedback on specific program changes that will support improved COD care. Routine screening would remain important to identify service members who might receive more appropriate treatment at a SARP certified in COD care. Regardless of where a service member receives treatment (either at a nearby military treatment facility or at another military treatment facility that specializes in CODs), all service members should have access to a site that is capable of providing care for CODs.

Recommendation 5. Implement measures to assess the quality of care provided at SARPs, including both process and outcomes measures.

We observed few mechanisms to monitor the quality of care delivered to service members for CODs, either at individual SARPs or across all SARPs. For example, we did not identify any measures assessing treatment process (e.g., use of evidence-based psychotherapy), which limits the ability to determine whether the care delivered is consistent with clinical practice guidelines. In addition, there are currently no systematic approaches for ongoing monitoring of client treatment outcomes. Integrating outcomes monitoring provides important information on the effectiveness of the services delivered. Further, outcomes monitoring is essential to delivering measurement-based care, in

which repeated assessments of client outcomes help to guide treatment delivery.

Conclusion

This report presents the results of an evaluation of a clinician training program to improve care for Navy personnel with CODs. These results suggest that clinicians perceived a need for such training, were open to receiving it, and generally viewed the training experience positively. However, the results also suggest variability in the level of integrated care delivered by the SARPs and indicate that many SARPs may not be providing integrated care. Results indicate that more careful planning and targeting of SARPs best suited to develop skills for treating CODs would improve the effectiveness of the training and, therefore, be more likely to translate into higher-quality care for service members with CODs.

Additional Methodological Details

In this appendix, we provide more methodological detail about our procedures.

Web Survey Measures

The survey (Appendix C) assessed a number of domains described below. Alphas were calculated using the web survey data collected for this study.

Demographics and Professional Characteristics were collected, including age, sex, race/ethnicity, provider type (e.g., alcohol and drug counselor, clinical psychologist), primary professional role at the SARP (clinician, administrator, both), current SARP location, and were asked whether they were currently at the same site at the time they received CODP training.

Characteristics of SARPs were assessed using selected items from the National Survey of Substance Abuse Treatment Services (Department of Health and Human Services, 2008). Items assess types of services available at the SARP, the proportion of clients who receive individual or group counseling, and how often various therapeutic approaches (e.g., CBT) are used at the SARP.

To measure *frequency of use of CODP materials since the training*, we developed nine items, which were rated on a five-point scale (0 = Never, 1 = Once or twice, 2 = A few times a year, 3 = Monthly, 4 = Weekly). Respondents were asked, "Which of the following best characterizes how often you used these CODP materials since the

training? Examples of 'use' include using handouts or measures in assessment or treatment, reading or reviewing the manuals, or using content to guide a session." Respondents were asked to rate the frequency with which they have used the CODP program curricula and specific program materials, a total of nine items (five curricula items: Administrator's Guidebook, Screening and Assessment, Integrating Combined Therapies, Cognitive Behavioral Therapy, Medication Management; and four materials items: Clinician's Guide, workbook factsheets, workbook handouts, screening/assessment measures). To examine factors that might be associated with *overall* implementation of the CODP materials, we summed the scores of all nine variables to create an "Adoption of CODP Materials" total score (α=0.92). To evaluate differential implementation of screening and treatment materials, we computed indicators of (1) adoption of CODP screening materials, and (2) adoption of CODP *therapy* materials. The screening variable was a sum of two items: frequency of use of the CODP screening and assessment guide, and frequency of use of the CODP screening and assessment measures. The indicator of adoption of CODP therapy materials was a sum of the items assessing frequency of use of the CBT and ICT guides.

Implementation and perceptions of the CODP materials, and barriers to implementation were measured using the Texas Christian University Workshop Assessment Follow-Up Workshop Assessment (Bartholomew et al., 2007). The Workshop Assessment is a 26-item questionnaire with acceptable reliability and validity that measures use and intentions to use training materials, program resources related to use, and barriers to use. We used several subscales of this measure that assessed the quality of the training, the quality and usefulness of the training materials, ability of participants to incorporate the materials in their workplaces, perceived support by participants' workplaces for implementing the training, and barriers to implementation. The Training subscale (three items; α = 0.76) assesses participants' views on the quality of the training. The Quality and Utilization subscale (four items; α = 0.93) assesses training participants' views about the quality and usefulness of the materials. The Resources and Skills subscale (five items; α = 0.77) measures participants' ability to incorporate the mate-

rials in their workplaces. The Support and Commitment subscale (five items; α = 0.89) identifies the extent to which implementing the skills learned at the training has been supported by colleagues and senior staff and has been sustainable. Lastly, the Barriers Encountered subscale (eight items; α = 0.88) was used to determine why participants did not use materials in their practice. All items were rated on a five-point scale (1 = Disagree Strongly, 2 = Disagree, 3 = Undecided, 4 = Agree, 5 = Agree Strongly), with one item on the Resources and Skills subscale reverse coded. Rescaled average scores were computed for the total and subscales (Bartholomew et al., 2007). To do this, the average score is computed and then multiplied by 10. Therefore, scale scores can range from 10 to 50.

The utility of the CODP was assessed using an eight-item measure created by Hazelden to assess the utility of the program. Psychometric properties are not available for this measure. Questions assess self-efficacy and achievement of different program objectives. Items are rated on a four-point scale, where 4 = Strongly agree, 3 = Somewhat agree, 2 = Somewhat disagree, 1 = Strongly disagree. The first three items were asked only of respondents who reported serving in administrative roles. Because the items assess diverse concepts, these items were examined individually.

Respondents also reported on the *supervision and additional training to support implementation of the CODP* they received after the Hazelden training. Specifically, respondents were asked whether they had *ever* received any clinical supervision to help perform assessments or deliver treatment using the CODP materials. If they answered "yes," they were also asked to report which modality of supervision was received (e.g., live observation, face-to-face meetings with supervisor, supervisor listened to audio recordings of sessions), and to estimate the number of CODP supervision sessions they had received since the training (0 = None, 1 = 1–5, 2 = 6–10, 3 = 11–15, 4 = 1620, 5 = 21 or more). Finally, respondents reported the number of other trainings on CODs they had attended since the CODP training at Hazelden.

Attitudes about the adoption of EBPs were measured with the 15-item Evidence-Based Practice Attitude Scale, which has acceptable reliability and validity (Aarons, 2004). This measure was selected

because resistance to using EBPs could be a barrier to implementation of the CODP. We used a number of subscales to assess trainees' perceptions of using EBPs, including subscales that assessed the appeal of EBPs, the influence of regulatory requirements, openness to new interventions, and views on clinical research. For the purposes of the current study, the item "if you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if it was required by your state" was removed from the Appeal subscale because it is not relevant for SARP staff. Therefore, there were 14 evidence-based attitudes-related items administered in the current study. The four attitude subscales consist of Appeal (four items; α = 0.92), Requirements (two items; α = 0.92), Openness (four items; α = 0.91), and Divergence (four items; α = 0.39). The Appeal subscale measures the extent to which the respondent would adopt a new practice if it were intuitively appealing, made sense, could be used correctly, or is being used by colleagues who are happy with it. The Requirements subscale asks respondents whether they would adopt a new practice if it were required by an agency, supervisor, or state. The Openness scale assesses the extent to which the respondent is generally open to trying new interventions and would be willing to try or use new types of therapy. Lastly, the Divergence subscale measures the respondent's views on the clinical utility of research-based interventions and relative importance of clinical experience (Aarons, 2004). In addition to the subscale scores, a total score was calculated (14 items; α = 0.92), reflecting global attitude toward the adoption of EBPs. Respondents were asked to answer each question based on a 0–4 scale (0 = Not at all, 1 = To a slight extent, 2 = To a moderate extent, 3 = To a great extent, 4 = To a very great extent). Mean scores were used for analyses including attitudes total and subscales.

Attitudes about treating clients with co-occurring disorders were assessed with the Clinician Attitudes Questionnaire (Hunter et al., 2005). This measure consists of seven items (e.g., "there is little to be done for clients that are mentally ill"), which are rated on a five-point scale (1 = Strongly disagree, 2 = Somewhat disagree, 3 = Neither disagree nor agree, 4 = Somewhat agree, 5 = Strongly agree). A mean attitudes score was computed (α = 0.83) (Hunter et al., 2005). This

measure was selected because negative attitudes about individuals with mental health problems (e.g., "People with mental illness have weak personalities") can serve as barriers to delivering effective treatment for CODs.

Attitudes about treating clients with SUDs were measured with the Brief Substance Abuse Attitude Survey (Chappel, Veach, and Krug, 1985). This is a 20-item survey derived from the longer Substance Abuse Attitude Survey. These items are rated a five-point scale (1 = Strongly disagree, 2 = Disagree, 3 = Uncertain, 4 = Agree, 5 = Strongly agree). This measure was selected because negative attitudes about clients with SUDs could be another barrier to effective implementation of the CODP. This measure consists of five subscales, which assess respondent beliefs about substance use, attitudes about substance abuse interventions, common substance abuse stereotypes, views on the utility of substance abuse treatment, and moral issues around substance abuse. The Permissiveness subscale (four items; α = 0.32) measures beliefs about substance use. The Treatment Intervention subscale (five items; α = 0.44) assesses attitudes toward various substance use interventions. The Non-Stereotypes subscale (three items; α = 0.43) assesses beliefs about common substance use stereotypes. The Treatment Optimism subscale (five items; α = 0.50) queries about beliefs that substance use treatment can lead to a successful outcome. Lastly, the Non-moralism subscale (three items; α = 0.43) assesses views on moral issues surrounding substance use and misuse. Hazelden added nine items to the measure to specifically inquire about attitudes about CODs and related issues, but these nine items were not analyzed for the current study, as they showed little variability and have not been empirically examined in previous studies.

Participants who were SARP administrators were asked to assess the *capability of their SARP to provide services for clients with co-occurring disorders* using the DDCAT, version 4.0. The DDCAT is a 35-item measure that was developed to assess capability to assess and treat co-occurring disorders and to guide addiction treatment providers in enhancing services for persons with co-occurring disorders. The reliability and validity of the DDCAT are acceptable (McGovern, Matzkin, and Giard, 2007). The DDCAT was presented and described to

CODP participants at the training. The DDCAT was designed to be rated by trained observers who use information from a variety of sources (e.g., staff and client interviews, observation of clinic materials and procedures, chart review) to compute scores across the seven domains. However, because it was not possible for the research staff to visit every site, we asked SARP administrators to rate their own SARPs on the web survey. Self-administered DDCAT scores tend to be positively biased (i.e., toward more desirable scores) by about one point on average (Lee and Cameron, 2009). We modified DDCAT items to be appropriate for self-report (as opposed to observer rated) and for the SARP setting. We consulted with the primary author of the DDCAT (Mark McGovern), who reviewed the modifications.

The DDCAT includes 35 items that are rated on a Likert Scale. The individual items assess the extent to which a site is able to provide COD treatment. Example items include "Are patients with mental health disorders expected and welcomed at your SARP?" and "To what extent is education about psychiatric disorders, their treatment, and their interaction with substance use & its treatment offered at your SARP?" The ratings range from 1 to 5, where 1 indicates that the SARP is capable of providing little to no treatment for mental health conditions, 3 indicates that the site can provide some COD treatment, and 5 indicates that the site provides comprehensive COD treatment. The DDCAT consists of seven subscales, which assess a SARP's program structure, program milieu, assessment of CODs, treatment of CODs, ability to provide continuity of care, staffing, and training. We computed mean subscale scores for each DDCAT subscale. Then we averaged the mean subscale scores to create a total score for the SARP, which can range from 1 (Addiction Only Services) to 5 (Dual Diagnosis Enhanced) and indicates the site's overall level of dual diagnosis capability.

Site Visit Selection

Survey DDCAT ratings of Addiction Only Services were considered to indicate low levels of integrated treatment, whereas Dual Diagnosis

Capable ratings were considered to indicate higher levels of integrated treatment. To categorize individuals into "high" or "low" adopters of the CODP materials, we counted the number of "adoption" variables on which each respondent's rating fell either one standard deviation below (low adoption) or above the sample mean (high adoption). The possible range for these variables was 0 to 9. For example, a respondent's frequency of use might be one standard deviation below the mean for two variables, one standard deviation above the mean for three variables, and within one standard deviation of the mean on the remaining four variables. Yet, another respondent could have reported using all nine CODP materials at a frequency one standard deviation above the mean. This respondent would be considered a high adopter. Next, we grouped respondents by SARP and simultaneously examined respondents' ratings on the DDCAT and the number of materials respondents reported using at a frequency falling one standard deviation below or above the mean. Given our reliance on self-reported data to select sites, we aimed to select sites where responses reliably reported high or low implementation of the CODP and integration of COD treatment. Therefore, in cases where we had multiple respondents from the same SARP, we selected those where respondents' reports were consistent in level of dual diagnosis capability (from the DDCAT) and/or level of adoption of the CODP materials. If there was only one respondent from a SARP, we selected sites where that respondent's DDCAT and adoption ratings were consistent with one another (e.g., rating Dual Diagnosis Capable on the DDCAT and reporting high adoption of CODP materials). Of the 19 SARPs for which we had DDCAT and/or adoption data, we removed seven sites from consideration due to inconsistent ratings. Another SARP was removed from the list because its overseas location made a site visit unfeasible. We then considered the size of the remaining 11 sites using data from BUMED on number of clients screened and treated, as well as resources available to each site (e.g., co-location with a major medical center).

We selected two "large, high-resource" sites, and two "small, low-resource" sites, weighting SARPs for which web survey respondents had completed the DDCAT (N = 6 of remaining 11) more heavily. Within each size category, there was one "high implementer/adopter"

and one "low implementer/adopter." It is important to note that selecting a site as a high or low implementer of the CODP does not necessarily reflect its capability to treat CODs. Also, self-reported information on level of implementation was available only from staff members who responded to the web survey. Other staff members at each SARP may have a higher or lower level of implementation of the CODP materials.

Key-Informant Discussion Guide

Key-Informant Questions—Hazelden

Hazelden Goals/Expectations
Questions to Initiate Discussion

1. What were your goals and expectations for implementation of the CODP into the SARPs?

Possible Prompts/Probes

2. Do you think your goal of _____ was met?
3. If you delivered the program to SARP staff again, what would you do differently?

Perceived Strengths for SARPs
Questions to Initiate Discussion

1. In what ways do you think the CODP has impacted the SARPs?

Possible Prompts/Probes

2. What were the specific strengths of the program?
3. What were the program's limitations?

Barriers/Facilitators of Implementation

Questions to Initiate Discussion
1. What factors influenced how easy or difficult it was for the SARPs to implement the CODP?

Possible Prompts/Probes

2. What supports did you plan to be there to help people implement skills? What supports were actually there?
3. What got in the way of effective implementation?
4. What made it easier to implement the CODP?

Key Informant Questions—BUMED

Goals and Expectations for Program
Questions to Initiate Discussion
1. What were your goals and expectations for selecting the CODP for implementation in the SARPs?

Possible Prompts/Probes

2. How did you select the CODP program for implementation in SARPs?
3. Do you think the program met the Navy's goals of _____?

Perceived Strengths for SARPs
Questions to Initiate Discussion
1. In what ways do you think the CODP has impacted the SARPs?

Possible Prompts/Probes

2. What were the specific strengths of the program?
3. What were the program's limitations?

Barriers/Facilitators of Implementation
Questions to Initiate Discussion

1. What factors influenced how easy or difficult it was for the SARPs to implement the CODP?

Possible Prompts/Probes

2. What supports did you plan to be there to help people implement skills? What supports were actually there?
3. What got in the way of effective implementation?
4. What made it easier to implement the CODP?

BUMED Perception of Program Value
Questions to Initiate Discussion

1. Tell me about the value of the program to the Navy.

Possible Prompts/Probes

2. What did the program cost?
3. Do you think the benefits of the program were worth the costs?
4. What factors will influence your decision to renew the CODP contract?
5. Are you planning to do this type of training again? Why or why not?
6. Would you work with Hazelden again for this type of training? Why or why not?

Web Survey

Table C.1
Online Program Survey

	Question	Response Option
SCREENING FOR SERVICE MEMBERS ONLY	Which of the following best describes your current status?	Active Duty or in an Active status; Retired from the US Military; Reserve status or National Guard; Spouse of a service member; Civilian
		If option 5: Unfortunately, you are not eligible to complete this survey as per our current institutional review board approvals. Thank you for your time.

Demographics

Sex	Are you	0. Male 1. Female
Age	How old are you?	Range: 18–99
Ethnicity	Are you of Hispanic or Latino origin or descent?	0. No 1. Yes
Race	What is your race? Please select one or more.	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaskan Native 6. NONE OF THESE (Please describe_____)

Table C.1—Continued

Question	Response Option
We would like to compare the results of this survey to results from similar measures that were completed at the Co-Occurring Disorders Program (CODP) Hazelden training. To do this, we will need to know the ID number you created and used at the training. The following three questions will tell us what your ID number was.	
What is the first letter of your mother's maiden name?	Fill in (A–Z)
What is the first digit of your social security number?	Fill in (0–9)
What is the last digit of your social security number?	Fill in (0–9)

Administrative

	Question	Response Option
Current SARP	At which site are you currently located?	1. 29 Palms 2. 77 Bush 3. Bahrain 4. Bethesda 5. Bremerton 6. Brunswick 7. Charleston 8. Corpus Christi 9. Diego Garcia 10. Fallon 11. Great Lakes 12. Groton 13. Guantanamo Bay 14. Guam 15. Gulfport 16. Jacksonville 17. Key West 18. Kings Bay 19. Lejeune 20. LeMoore

Table C.1—Continued

Question	Response Option
	21. Naples
	22. Naval Health Clinic Annapolis
	23. Naval Health Clinic New England
	24. Naval Medical Center Portsmouth
	25. Navy Drug and Alcohol Counselor School
	26 New London
	27. Newport, RI
	28. Norfolk
	29. Oak Harbor
	30. Okinawa
	31. Parris Island
	32. Pax River
	33. Pearl Harbor
	34. Pendleton
	35. Port Hueneme
	36. Port Loma
	37. Rota, Spain
	38. San Diego
	39 Sasebo
	40. Sigonella
	41. Stennis
	42. USS Abraham Lincoln
	43. USS Frank Cable
	44. USS George Washington
	45. USS Harry S. Truman
	46. USS Nimitz
	47. USS Ronald Reagan
	48. Whidbey Island
	49. Willow Grove
	50. Yokosuka
	51. Other (PLEASE SPECIFY: _____)
Changed SARP since training	When you attended the Co-Occurring Disorders Program (CODP) Hazelden training, were you located at this same site?	0. No 1. Yes

Table C.1—Continued

	Question	Response Option
Provider type	What type of provider are you?	1. Certified Drug Abuse Counselor (CADAC) 2. Clinical Psychologist 3. Clinical Social Worker 4. Licensed Chemical Dependency Counselor (LCDC) 5. Navy Alcohol and Drug Counselor I (ADCI) 6. Navy Alcohol and Drug Counselor II (ADCII) 7. Licensed Independent Practitioner 8. Psychiatric Nurse 9. Psychiatrist 10. NONE OF THESE (PLEASE DESCRIBE: [FILL IN BLANK])
Position	What is your primary professional role at your SARP?	1. Administrator 2. Counselor or Clinician 3. Administrator and Counselor/Clinician
Supervision	**The following questions ask about the amount and type(s) of supervision you received after the Co-Occurring Disorders Program (CODP) training at Hazelden to help you implement the skills you learned. "Supervision" is feedback or coaching delivered to the treatment provider by another professional with relevant experience and/or expertise.**	
Supervision ever	After you completed the CODP training at Hazelden, did you receive any clinical supervision to help you perform assessments and/or deliver treatment using the CODP materials?	0. No 1. Yes

Table C.1—Continued

	Question	Response Option
Supervision type	What modality of CODP supervision do/did you receive? (Check all that apply.)	1. Face to face (in person) or telephone meetings with supervisor 2. Supervisor listened to audio recorded sessions 3. Supervisor watched video recorded sessions 4. Live observation 5. Peer consultation 6. Other (PLEASE DESCRIBE: [FILL IN BLANK])
Number supervision sessions	Please estimate the number of CODP supervision sessions you have had since the training.	1. None 2. 1–5 3. 6–10 4. 11–15 5. 16–20 6. 21 or more
Other trainings on COD since CODP	How many other trainings on co-occurring disorders have you participated in since you completed the CODP program?	0–100

Table C.1—Continued

Question	Response Option
Facility characteristics	
Types of services	**Please consider the primary SARP in which you work. Which of the following services are provided by this SARP? (MARK ALL THAT APPLY)**	1. Screening for substance use 2. Screening for mental health 3. Comprehensive substance abuse assessment or diagnosis 4. Comprehensive mental health assessment or diagnosis (for example, psychological or psychiatric evaluation and testing) 5. Outreach to persons in the community who might need treatment 6. Interim services for clients when admission is not possible 7. Discharge planning 8. Aftercare/continuing care 9. Case management 10. Social skills development 11. Mentoring/peer support 12. Substance abuse education 13. Mental health education 14. Self-help groups 15. Medication Assisted Therapy (e.g., Antabuse, Naltrexone, Campral, Methadone, Buprenorphine) 16. Smoking cessation medications (nicotine replacement or non-nicotine) 17. Medications for psychiatric disorders
Counseling Type	**For each type of counseling below, please indicate approximately what percentage of substance abuse clients at this SARP receive that type of counseling as part of their substance abuse treatment program.**	

Table C.1—Continued

Question	Response Option
Individual counseling	1. Not offered 2. Received by 25% or less of clients 3. Received by 25% to 50% of clients 4. Received by 51% to 75% of clients 5. Received by more than 75% of clients
Group counseling	1. Not offered 2. Received by 25% or less of clients 3. Received by 25% to 50% of clients 4. Received by 51% to 75% of clients 5. Received by more than 75% of clients
Therapeutic approach **For each type of clinical/ therapeutic approach listed below, please mark the box that best describes how often that approach is used at this SARP.**	
Substance use counseling	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often
12-step facilitation	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often
Supportive counseling	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often
Cognitive behavioral therapy	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often

Table C.1—Continued

Question	Response Option
Contingency management or motivational incentives	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often
Motivational interviewing	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or often
Combined cognitive behavioral therapy (CBT), motivational interviewing (MI), 12-Step facilitation for treating co-occurring disorders	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or Often
Relapse prevention	1. Not familiar with this approach 2. Never or rarely 3. Sometimes 4. Always or Often
Does the facility offer a special program for clients with co-occurring disorders?	0. No 1. Yes

Program utility

Self-efficacy/ achievement of program objectives

Please rate the extent to which you Agree or Disagree with each statement. (You may have answered some of these questions right after you finished the CODP; we are most interested in how you are feeling about the CODP now).

Question	Response Option
As a result of attending the CODP, I believe I am better able to assess seven areas of organizational effectiveness presented in the CODP clinical administrator's guidebook.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities

Table C.1—Continued

Question	Response Option
As a result of attending the CODP, I believe I am better able to interpret comprehensive guides for assessing an organization's capacity for treating non-severe co-occurring disorders: Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Disorders Capability in Mental Health Treatment (DDCMHT).	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
As a result of attending the CODP, I believe I am better able to identify system, program, and staff-level issues and challenges in providing integrated services.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
As a result of attending the CODP, I believe I am better able to use protocol-driven screening methods that consider each person's symptoms, history, and motivation to change.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
As a result of attending the CODP, I believe I am better able to combine Motivational Enhancement Therapy (MET), Cognitive Behavioral Therapy (CBT), and Twelve-Step Facilitation (TSF) to engage, assist, and sustain change.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
As a result of attending the CODP, I believe I am better able to use Cognitive-Behavioral Therapy to address common psychiatric problems, such as depression, anxiety, PTSD, and others.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities

Table C.1—Continued

	Question	Response Option
	As a result of attending the CODP, I believe I am better able to examine PTSD and military related disorders, including Traumatic Brain Injury (TBI).	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
	As a result of attending the CODP, I believe I am better able to convey vital and current information on medication compliance, stigma, and other psychopharmacological issues.	4. Strongly agree 3. 2. 1. Strongly disagree Not applicable to my job responsibilities
CODP curricula and materials: adoption barriers, sustainability, fidelity		
Use of program curricula	**Which of the following best characterizes how often you used these CODP materials since the training? Examples of "use" include using handouts or measures in treatment or assessment, reading or reviewing the manuals, or using content to guide a session.**	
Frequency of use of each binder	Administrator's Guidebook	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
	Screening and Assessment	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly

Table C.1—Continued

Question	Response Option
Integrating Combined Therapies	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
Cognitive Behavioral Therapy	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
Medication Management	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly

Quantity of use of specific materials

Which components of the materials do you use?

Question	Response Option
Clinician's guide	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
Workbook fact sheets	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
Workbook handouts	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly
Screening/assessment measures	0. Never 1. Once or twice 2. A few times a year 3. Monthly 4. Weekly

The next items ask you to consider some factors that might influence your use of the CODP materials.

Table C.1—Continued

Question		Response Option
Adoption of program materials	You were <u>satisfied</u> with the materials and ideas presented in the materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	The materials have proved to be <u>relevant</u> to the needs of your clients or your program.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	You have been <u>comfortable</u> using them.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	You have found the things you learned <u>are useful</u> to you and your clients/staff.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	Your program has <u>enough staff capacity</u> to implement these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	Your program has <u>adequate office space</u> <u>and budget</u> to implement these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	You have had <u>enough preparation time</u> to use these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
	Others in your program have <u>not</u> implemented these materials effectively.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly

Table C.1—Continued

Question	Response Option
Counselors in your program have <u>adequate background and training</u> needed to use these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
<u>Practice sessions</u> during the training gave you confidence in using the materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
The training provided <u>good instructions and examples</u> for adapting the materials to your clients' needs.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
Based on what you learned, you have been able to <u>train others</u> to use these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
A <u>follow-up training session</u> is needed to really use these materials effectively.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
Your <u>program director (or clinical supervisor)</u> has supported and encouraged use of these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
<u>Other staff</u> at your program have become <u>interested in learning</u> to use these materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
Staff at your program <u>like to help one another</u> when using new materials like these.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly

Table C.1—Continued

Question	Response Option
Your clients/staff <u>benefited from and encouraged</u> your use of the materials.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
You have found ways to make these materials a <u>regular and sustained</u> part of your program.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly

Barriers to using program materials

You have not used the CODP materials more often because …

Question	Response Option
… you have a lack of time.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… you already use things you like better.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… they do not fit with your counseling style.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… your agency does not have the time or resources needed.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… they have not worked with your clients.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly

Table C.1—Continued

Question	Response Option
… you do not feel properly trained to use them.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… they seem cumbersome and difficult to use.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
… they do not comply with the treatment philosophy at your agency.	1. Disagree Strongly 2. Disagree 3. Undecided 4. Agree 5. Agree Strongly
Other: Please specify	

Attitudes

	Question	Response Option
Evidence-based practices attitudes survey	**The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy, treatment, or intervention refers to any intervention that has specific guidelines and/ or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way. Indicate the extent to which you agree with each item.**	
	I like to use new types of therapy/interventions to help my clients.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent

Table C.1—Continued

Question	Response Option
I am willing to try new types of therapy/ interventions even if I have to follow a treatment manual.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
I know better than academic researchers how to care for my clients.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
I am willing to use new and different types of therapy/ interventions developed by researchers.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
Research-based treatments/ interventions are not clinically useful.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
Clinical experience is more important than using manualized therapy/ interventions.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
I would not use manualized therapy/interventions.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
I would try a new therapy/ intervention even if it were very different from what I am used to doing.	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
For questions 9–15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:	

Table C.1—Continued

Question	Response Option
… it was intuitively appealing?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
… it "made sense" to you?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
… it was required by your supervisor?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
… it was required by your SARP or the Navy?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
… it was being used by colleagues who were happy with it?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent
… you felt you had enough training to use it correctly?	0. Not at all 1. To a slight extent 2. To a moderate extent 3. To a great extent 4. To a very great extent

Clinician attitudes towards patients with mental health disorders

Using the scale below, please indicate how much you agree with the following statements.

Question	Response Option
It is bad for people with drug and/or alcohol problems to use medications.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree

Table C.1—Continued

Question	Response Option
There is little to be done for clients that are mentally ill.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
It is easy to recognize someone who has a mental illness.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
People with dual diagnosis should get better with abstinence and should not have to rely on medication.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
People with mental illness have weak personalities.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
Psychiatric medications are merely a replacement for the drug of choice.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
People with dual diagnosis are only trying to get on disability payrolls.	1. Strongly Disagree 2. Somewhat Disagree 3. Neither Agree nor Disagree 4. Somewhat Agree 5. Strongly Agree
Brief substance abuse attitudes survey	**Indicate your degree of agreement or disagreement by circling the appropriate choice to the right of each statement. There are no right or wrong answers.**
Addiction is associated with weak will.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree

Table C.1—Continued

Question	Response Option
An addicted person cannot be helped until he/she has hit "rock bottom."	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Heroin is so addicting that no one can really recover once he/she becomes an addict.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Alcohol and drug abusers should only be treated by specialists in that field.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Smoking leads to marijuana use, which in turn leads to hard drugs.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Professionals who diagnose alcoholism early improve the chance of treatments success.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Daily use of one marijuana cigarette is not necessarily harmful.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Urine drug screening can be an important part of drug abuse treatment.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
A professional who has been addicted to narcotics should be allowed to practice within their field again.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree

Table C.1—Continued

Question	Response Option
Marijuana use among teenagers can be healthy experimentation.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
An addicted person who has relapsed several times probably cannot be treated.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Long-term outpatient treatment is necessary for the treatment of addiction.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Paraprofessional counselors can provide effective treatment for addicted individuals.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Lifelong abstinence is a necessary goal in the treatment of addiction.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Once a person becomes chemical-free through treatment, she or he can never become a social user.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Drug addiction is a treatable disease.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Group therapy is very important to the treatment of addiction.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree

Table C.1—Continued

Question	Response Option
A hospital is the best place to treat an alcohol or drug addict.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Alcoholism is a treatable disease.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Most addicted persons are unpleasant to work with as patients.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Pregnant women who use alcohol and other drugs should be punished.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Coercive pressure, such as threat of punishment, is useful in getting resistant patients to accept treatment.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
A recovering person who is active in Alcoholics Anonymous does not respond well to psychotherapy.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
A professional who has been drug dependent should not be allowed to give medications to patients.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Active participation in a program such as AA is essential for a patient to recover from alcohol or drug dependence.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree

Table C.1—Continued

	Question	Response Option
	I feel comfortable in interviewing a patient with substance abuse problems.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
	I feel able to take a complete history from a patient with substance abuse problems.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
	I feel competent to make a diagnosis of alcohol/drug abuse or dependence.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
	I feel equipped to recommend appropriate treatment referrals for substance abuse patients.	1. Strongly Disagree 2. Disagree 3. Uncertain 4. Agree 5. Strongly Agree
Dual-diagnosis capability		
DDCAT assessment		
	When you attended the CODP training, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) was introduced. The DDCAT is a rating system that clinic administrators can use to assess their clinic's capability to serve dual diagnosis clients. We are presenting the DDCAT again. Within each domain please select the response that best applies to your program or agency.	

Table C.1—Continued

	Question	Response Option
Program structure	What is the primary focus of your SARP?	1. Addiction only. 2. Primary focus is addiction, but co-occurring disorders are treated. 3. Primary focus on persons with co-occurring disorders.
	What does your SARP's organizational certification and licensure permit?	1. Permits only addiction treatment. 2. Has no actual barrier, but staff report there to be certification or licensure barriers. 3. Has no barrier to providing mental health treatment or treating co-occurring disorders within the context of addiction treatment. 4. Is certified and/or licensed to provide both mental health and addiction treatment.
	To what extent does your SARP coordinate and collaborate with mental health services?	1. There is no formal or documented coordination or collaboration. 2. There is vague, undocumented or informal relationship with mental health agencies, or consulting with a staff member from that agency. 3. There is formalized and documented coordination or collaboration with mental health agency. 4. There is formalized coordination & collaboration, and also the availability of case management staff, or staff exchange programs. 5. Most mental health services are integrated within the existing program, or there is routine use of case management staff or staff exchange programs.

Table C.1—Continued

	Question	Response Option
	What is the billing structure at your SARP? Can you bill for mental health disorders, substance use disorders, or both?	1. We can only bill for addiction treatments for persons with substance use disorders. 2. We could bill for either type if substance use disorder is primary, but staff report there to be barriers. -OR- Partial reimbursement for mental health services are available. 3. We can bill for either service type; however, substance use disorder must be primary. 4. We can bill for addiction or mental health treatments or the combination and/or integration.
Program milieu	Are patients with mental health disorders expected and welcomed at your SARP?	1. My SARP expects substance use disorders only, We refer or deflect persons with mental health disorders or symptoms. 2. My SARP is documented to expect substance use disorders only (e.g. admission criteria, target population), but we have informal procedure(s) to allow some persons with mental health problems to be admitted. 3. We expect substance use disorders, and, with documentation, accept mental health disorders by routine and if mild and relatively stable. 4. Our program is formally defined such that we only expect substance use disorders, but our clinicians and program informally expect and treat both disorders. 5. Our clinicians and program expect and treat both disorders, and this is well documented.

Table C.1—Continued

	Question	Response Option
	What is the focus of patient literature and education materials in your SARP?	1. Only addiction or peer support (e.g., AA) materials are displayed and distributed. 2. Materials are available for both disorders but not routinely offered or formally available. 3. Materials are available for both mental health & substance use disorders, but distribution is less for mental health problems. 4. Materials are available for both mental health & substance use disorders with equivalent distribution. 5. Materials are available for the interaction between mental health and substance use disorders.
Clinical process: assessment	How are psychiatric symptoms screened in your SARP?	1. Pre-admission mental health screening depends on patient self-report. The decision whether to screen is based on clinician inference from patient presentation or by history. 2. Pre-admission mental health screening and symptom & treatment history, current psychiatric medications, and/or suicide/homicide history are conducted prior to admission. 3. There is a routine set of standard interview questions for mental health using a generic framework, such as the ASAM-PPC (Dimension III) or "Biopsychosocial" data collection.

Table C.1—Continued

Question	Response Option
	4. We screen for mental health problems using standardized or formal instruments with established psychometric properties.
	5. We use standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
What is the assessment routine if a patient screens positive for psychiatric symptoms?	1. There is ongoing monitoring of psychiatric symptoms to determine patient appropriateness or exclusion from the program.
	2. Clinicians conduct a detailed biopsychosocial assessment and/or mental status exam.
	3. We conduct formal mental health assessments, if necessary.
	4. We conduct or obtain follow-up mental health assessments, although these are not standardized or routine.
	5. We use standardized or formal integrated mental health and substance use assessment in all cases.
To what extent are psychiatric and substance use diagnoses made and documented at your SARP?	1. Psychiatric diagnoses are not made or recorded.
	2. Mental health diagnostic impressions are made and recorded variably.
	3. Mental health diagnosis is variably recorded in the patient's chart.
	4. Mental health diagnosis is frequently recorded, but inconsistently.
	5. Standard & routine mental health diagnoses are consistently made.

Table C.1—Continued

Question	Response Option
How are patients' psychiatric and substance use histories reflected in their medical records?	1. We collect substance use disorder history only. 2. Our standard protocol collects substance use disorder history only. Mental health history is collected inconsistently. 3. We routinely document both mental health and substance use disorder history in the narrative section of patient records. 4. There is a specific section in our patients' records dedicated to history and chronology of course of both disorders. 5. There is a specific section in records devoted to history and chronology of course of both disorders and the interaction between them is examined over time.
What level of psychiatric symptom acuity is required to be admitted into your SARP? Acuity refers to the level of need, or urgency, of the symptoms.	1. We admit people with no to low psychiatric symptom acuity. 2. We admit people with low to moderate acuity but who are primarily stable. 3. We admit people with moderate to high acuity, including those unstable in their psychiatric condition.
What level of psychiatric symptom severity and persistence is required to be admitted into your SARP?	1. We admit people into our program who have no to low severity or persistence of mental health disability. 2. We admit people into our program with low to moderate psychiatric symptom severity. 3. We admit people into our program with moderate to high psychiatric symptom severity.

Table C.1—Continued

	Question	Response Option
	Does your SARP assess patients' stages of change?	1. Stages of change are not assessed or documented. 2. Stages of change are assessed & documented variably depending on the individual clinician. 3. Clinicians assess and routinely document stages of change, which are focused on substance use disorders motivation. 4. Formal measures are used and stages of change are routinely documented, but focus on substance use disorders motivation only. 5. Formal measures are used and stages of change are routinely documented, and focus on both substance use and mental health motivation.
Clinical process: treatment	What is the focus of treatment plans in your SARP?	1. Our treatment plans address addiction only. 2. It depends on the individual clinician. 3. In our treatment plans, substance use disorders are addressed as the primary problem, with mental health as secondary. 4. Our plans routinely address both substance use and mental health disorders, but the amount of detail for each type of disorder varies. 5. Our treatment plans address both substance use and mental health disorders as primary, and both are listed in plans consistently.
	How does your SARP assess and monitor the courses of substance use and mental health disorders?	1. We do not track progress with mental health problems. 2. Report of progress on mental health problems varies depending on the individual clinician.

Table C.1—Continued

Question	Response Option
	3. Clinicians routinely note changes in mental health problems in their treatment plans and progress notes.
	4. We have tools available for clinicians to systematically monitor and document changes in both substance use and mental health disorders, but use of these tools depends on the clinician.
	5. We consistently and systematically focus on change in both substance use and mental health disorders in a detailed fashion.
How are procedures for psychiatric emergencies and crisis management conveyed in your SARP?	1. No guidelines for psychiatric emergencies are conveyed in any manner.
	2. In-house guidelines are verbally conveyed.
	3. We have documented guidelines that suggest referral to or collaboration with others (e.g., local mental health agency or ER).
	4. We have documented guidelines, risk assessment tools, and advance directives, but these are not consistently used.
	5. We have documented guidelines, risk assessment tools, and advance directives, and they are consistently used. We keep patients in our program unless inpatient hospitalization is warranted.
To what extent does your SARP use stage-wise treatment?	1. Stages of change are not assessed or explicit in treatment plans.
	2. Stage of change or motivation are sometimes documented in treatment plans by some clinicians.

Table C.1—Continued

Question	Response Option
	3. Stage of change or motivation are routinely incorporated into individualized plans, but no specific stage-wise treatments are provided. 4. Stage of change or motivation are routinely incorporated into individualized plans, and there is a general awareness of the value of adjusting treatments by substance use stage of change or motivation. 5. Stage of change or motivation are routinely incorporated into individualized plans, and stage-wise treatments are formally prescribed and delivered for both substance use and mental health issues.
What are your policies and procedures for medication evaluation, management, monitoring, and compliance?	1. Patients on meds are typically not accepted. 2. Certain types of meds are not acceptable, or the patient must have his/her own supply for the entire treatment episode. We have some capacity to monitor psychotropic medications. 3. Patients have some access to a prescriber for psychotropic medications, and we have policies to guide prescribing within the program. Monitoring of the medication is largely done by the prescriber.

Table C.1—Continued

Question	Response Option
	4. Our medicating provider is a staff member who has clear standards and routines. Patients have regular access to the prescriber and guidelines for prescribing are in place. The prescriber sometimes consults with other staff regarding the medication plan and recruits other staff to assist with medication monitoring.
	5. Our medicating provider is also a staff member and is present on treatment teams or in the SARP administration. S/he has clear standards and routines. Patients have full access to the prescriber and appropriate prescribing guidelines are in place. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring.
Are there specialized mental health interventions in your SARP?	1. Mental health is not addressed in our program content.
	2. Incorporation of mental health material is up to the individual clinician.
	3. We have generalized mental health interventions, (e.g., stress management). Clinicians routinely provide evidence-based addiction treatment (e.g., Motivational Interviewing, CBT, TSF) that may have mental health content.

Table C.1—Continued

Question	Response Option
	4. In addition to routine generalized interventions, we have some specialized interventions provided by specifically trained clinicians. 5. We routinely offer mental health symptom management groups. We have individual therapies focused on specific disorders, and systematically use an evidence-based addiction treatment (e.g., Motivational Interviewing, CBT, TSF).
To what extent is education about psychiatric disorders, their treatment, and their interaction with substance use & its treatment offered at your SARP?	1. Not offered 2. This is sometimes offered. 3. We offer general information, delivered in individual and/or group formats. 4. We sometimes provide education in specific content areas in some group or individual settings. 5. We offer specific content for specific disorder co-morbidities, and deliver it in individual and/or group formats.
To what extent does your SARP offer family education and support?	1. We offer this for alcohol or drug problems only, or not at all. 2. We sometimes offer this, depending on individual clinical judgment. 3 Mental health issues are regularly but informally incorporated into family education or support sessions, which are available as needed.

Table C.1—Continued

Question	Response Option
	4. We sometimes offer generic groups on substance use and mental issues on site for families. 5. We routinely and systematically provide co-occurring disorder family groups, which are integrated into our standard program format.
Does your SARP have specialized interventions to facilitate the use of peer support groups?	1. We do not use interventions to facilitate the use of either addiction or mental health peer support. 2. These interventions are sometimes used by individual clinicians for individual patients, mostly for facilitation of addiction peer support groups. 3. We routinely facilitate traditional addiction, but not mental health, peer support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous). 4. We sometimes facilitate peer support groups targeting specific mental health issues, either traditional peer support groups or those specific to both substance use and mental health (e.g., Dual Recovery Anonymous, Double Trouble in Recovery, etc.). 5. We routinely and specifically facilitate peer support groups to address the needs of co-occurring persons. We have special programs on site, which are routinely targeted to specific issues.

Table C.1—Continued

	Question	Response Option
	Are peer recovery supports available for patients with co-occurring disorders?	1. We do not have such groups; if these groups are available, they are not recommended. 2. There are groups off site, and they are sometimes recommended. 3. There are groups facilitated off site. We work with a contact person or use an informal matching process with peer supports in the community. The groups have some co-occurring focus. 4. Groups are available off site, are integrated into patients' treatment plans, and have a co-occurring focus. 5. Groups are available on site, and are facilitated and integrated into our program (e.g. alumni groups); these groups are routinely used and have a co-occurring focus.
Continuity of care	To what extent are co-occurring disorders addressed in the discharge planning process at your SARP?	1. Co-occurring disorders are not addressed in discharge planning. 2. Co-occurring disorders are sometimes addressed by certain clinicians. 3. Co-occurring disorders are systematically addressed as secondary in the planning process for offsite referral. 4. We address both substance use and mental health disorders as priorities in our discharge plans a lot but not always (e.g., less than 80% of the time). 5. Both mental health and substance use disorders are seen as primary in discharge plans, and we make plans for on- or off-site follow-up at least 80% of the time.

Table C.1—Continued

Question	Response Option
Does your program have the capacity to provide continuing care for co-occurring disorders after addiction treatment?	1. We have no mechanism for managing ongoing care of mental health needs when the addiction treatment program is completed. 2. We have no formal protocol to manage mental health needs once the program is completed, but some individual clinicians may provide extended care until appropriate linkage takes place. 3. No formal protocol is in place to manage mental health needs once the program is completed. When indicated, however, most individual clinicians provide extended care until appropriate linkage takes place. 4. We have a formal protocol to manage mental health needs indefinitely, but this is not routinely practiced. 5. We have a formal protocol to manage mental health needs indefinitely and this is routinely practiced.
Does your program focus on ongoing recovery issues for both substance use and mental health disorders?	1. No. 2. This depends on the individual clinician. 3. We routinely focus on recovery from addiction, and mental health issues are viewed only as potential relapse issues. 4. We routinely focus on addiction recovery and mental health illness management and recovery. Both are seen as primary and ongoing.

Table C.1—Continued

Question	Response Option
Do you have specialized interventions to facilitate use of community-based peer support groups during discharge planning?	1. We have no interventions to facilitate use of either addiction or mental health peer support groups upon discharge. 2. Individual clinicians sometimes address this, mostly for facilitation to addiction peer support groups upon discharge. 3. We have some generic interventions, but no specific or intentional facilitation based on mental health disorders. We have more routine facilitation to addiction peer support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous) upon discharge. 4. We sometimes provide interventions targeting specific co-occurring needs to facilitate use of addiction or co-occurring disorders peer support groups upon discharge. 5. We routinely and systematically conduct such interventions, with a focus on co-occurring needs to facilitate use of peer support groups for addiction or co-occurring disorders after discharge.
Do you have a supply and compliance plan for medications?	1. We have no such medications plan. 2. Sometimes we have a 30-day medication plan, or can supply medication until the next off-site appointment. 3. We routinely have a 30-day plan or supply to next appointment off-site. 4. Medication management is maintained within our program until the patient is admitted to the next level of care at a different provider. 5. Medication management is maintained in our program.

Table C.1—Continued

	Question	Response Option
Staffing	Does your SARP have a psychiatrist or other physician or prescriber of psychotropic medications?	1. We have no formal relation-ship with a prescriber for this program. 2. We work with a consultant or contractor <u>off</u> site. 3. We work with a consultant or contractor <u>on</u> site. 4. We have a staff member to do this. S/he is present on site for clinical matters only. 5. We have a staff member to do this. S/he is present on site for clinical, supervi-sion, treatment team, and/or administration.
	What portion of your SARP's on-site clinical staff members have mental health licensure (doctoral or master's level), or similar competency/experience?	1. None. 2. 1–24% of our clinical staff members. 3. 25–33% of clinical staff members. 4. 34–49% of clinical staff members. 5. 50% or more of clinical staff members.
	Do your staff have access to mental health supervision/consultation?	1. No. 2. Our staff have access to off-site supervision by a consultant. 3. On-site supervision is pro-vided as needed by a con-sultant, contractor, or staff member. 4. On site supervision is pro-vided regularly by a staff member. 5. On site supervision is rou-tinely provided by a staff member and focuses on in-depth learning.

Table C.1—Continued

Question	Response Option
Does your SARP conduct case review, staffing, or utilization review procedures that emphasize and support co-occurring disorder treatment?	1. No, these are not conducted. 2. These are sometimes conducted by an off-site consultant. 3. These are conducted on site, documented, and cover co-occurring disorder issues as needed. 4. These are routinely conducted and documented, but do not systematically cover co-occurring issues. 5. These are routinely conducted and documented, and systematically cover co-occurring issues.
Is there peer/alumni support available for co-occurring disorders?	1. Not available. 2. These supports are available, but as part of the community. Some clinicians might refer their patients to these supports. 3. These supports are available, but as part of the community. Referrals are made routinely through clinician relationships or more formal connections such as peer support service groups (e.g., Alcoholics Anonymous hospital and institutional committees; National Alliance on Mental Illness). 4. These supports are available on site, either as paid staff, volunteers, or program alumni. Referrals are sometimes made. 5. Referrals are routinely made to these supports, which are available on site, either as paid staff, volunteers, or program alumni.

Table C.1—Continued

	Question	Response Option
Training	What portion of your SARP's staff members have <u>basic</u> training in attitudes, prevalence, common signs & symptoms, detection, and triage for co-occurring disorders?	1. No staff have basic training (0% trained). 2. Some are trained, but we have no systematic training plan (1–24% of staff trained). 3. Certain staff are trained with a systematic training plan, and they are encouraged by management (25–50% of staff trained). 4. Many staff are trained and monitored by our program's strategic training plan (51–79% of staff trained). 5. Most staff are trained, and are periodically monitored by our program's strategic training plan (80% or more of staff trained).
	What portion of your SARP's staff members have <u>advanced</u> specialized training in integrated or psychosocial or pharmacological treatment of people with co-occurring disorders?	1. No staff have advanced training (0% trained). 2. Some are trained, but we have no systematic training plan (1–24% of staff trained). 3. Certain staff are trained with a systematic training plan, and they are encouraged by management (25–50% of staff trained). 4. Many staff are trained and monitored by our program's strategic training plan (51–79% of staff trained). 5. Most staff are trained, and are periodically monitored by our program's strategic training plan (80% or more of staff trained).
	We are conducting telephone interviews with a select number of survey respondents so that we can get more in depth information about implementation of the training program. We expect the interviews will take up to 45 minutes.	

Table C.1—Continued

Question	Response Option
Are you interested in learning more about participating in an interview?	0. No 1. Yes
IF INTERVIEW = 1 **Thank you for participating in this study. Your responses will help us to improve care for individuals with co-occurring disorders. If you are selected as a potential participant for a telephone interview, we will contact you via email within a few weeks.**	
IF INTERVIEW = 0 **Thank you for participating in this study. Your responses will help us to improve care for individuals with co-occurring disorders.**	

Staff Discussion Guide

Table D.1
Staff Discussion Guide

Topic	Question to Initiate Discussion	Possible Prompts/Probes
Program utility	Tell me a bit about your experience participating in the CODP program.	
Program met CODP goal		*Do you think the program met its goals of …*
What were personal goals		*What were your goals for attending the CODP?*
Program met personal goals		*Did CODP meet these goals? Why? Why not?*
Program met CODP objectives		*Can you talk about how well the CODP expanded the capability of your program to treat clients with co-occurring substance use and mental health disorders?*
CODP curricula and materials: implementation, sustainability, barriers	During the CODP training, you designed an Action Plan describing the specific ways you intended to use the CODP materials for intake and assessment, care/treatment, and relapse prevention/continuing care with your clients. Of course, this was a long time ago and things may have changed a lot since then. Let's look at your Action Plan together and I'd like to ask you some questions about which components you implemented, which you didn't, and for what reasons.	
Intake and assessment phase	You mentioned in your Action Plan that you wanted to [fill in with actual text from individual's plan] to improve intake and assessment for clients with co-occurring disorders.	

Table D.1—Continued

Topic	Question to Initiate Discussion	Possible Prompts/Probes
Implementation of Action Plan		*How regularly do you [fill in with actual text from plan]?*
Facilitators		*What kinds of things help or would have helped to implement this part of your plan more often or more effectively?*
Barriers		*What kind of things have or could have gotten in the way of being able to implement this part of your plan?*
Importance		*How important is this part of your plan for the work that you do?*
Sustainability		*Do you think you'll keep doing it? Why or why not?*
Care phase	You mentioned in your Action Plan that you wanted to [fill in with actual text from individual's plan] to improve care for clients with co-occurring disorders.	
Implementation of Action Plan		*How regularly do you [fill in with actual text from plan]?*
Facilitators		*What kinds of things help or would have helped to implement this part of your plan more often or more effectively?*
Barriers		*What kind of things have or could have gotten in the way of being able to implement this part of your plan?*
Importance		*How important is this part of your plan for the work that you do?*
Sustainability		*Do you think you'll keep doing it? Why or why not?*
Relapse prevention/ continuing care phase	You mentioned in your Action Plan that you wanted to [fill in with actual text from individual's plan] to improve relapse prevention/continuing care for clients with co-occurring disorders.	
Implementation of Action Plan		How regularly do you [fill in with actual text from plan]?

Table D.1—Continued

Topic	Question to Initiate Discussion	*Possible Prompts/Probes*
Facilitators		*What kinds of things help or would have helped to implement this part of your plan more often or more effectively?*
Barriers		*What kind of things have or could have gotten in the way of being able to implement this part of your plan?*
Importance		*How important is this part of your plan for the work that you do?*
Sustainability		*Do you think you'll keep doing it? Why or why not?*

** THE REMAINING QUESTIONS/TOPICS WERE ASKED WHEN RELEVANT BASED ON THE PARTICIPANT'S SURVEY RESPONSES.

Topic	Question to Initiate Discussion	*Possible Prompts/Probes*
Administrator's Guidebook	**You mentioned in your survey that you used the Administrator's Guidebook to [fill in what they said in survey]. Can you tell me more about how you used the Guidebook?**	
Adoption of Administrator's Guidebook		*Which domains did you work on?*
Utility of Administrator's Guidebook		*Tell me about the usefulness of the Guidebook in helping you expand your program's dual diagnosis capability.*
Sustainability of Administrator's Guidebook		*Do you think the changes will last? Why or why not?*
Barriers to using Administrator's Guidebook		*Tell me about the barriers to using the Guidebook.*
Changes made using Administrator's Guidebook		*Talk about some of the changes you made to the program using the Guidebook.*
Performance Measurement		*What are your thoughts about using the DDCAT as an ongoing measure of program performance?*
Screening and Assessment Curriculum (#1)	Tell me about your use of the Screening and Assessment Curriculum.	

Table D.1—Continued

Topic	Question to Initiate Discussion	*Possible Prompts/Probes*
Adoption of Screening and Assessment Curriculum		*Did you use the assessments or screeners in the curriculum? Why or why not?*
Utility of Assessment Curriculum		*Tell me about the usefulness of the Screening and Assessment Curriculum in helping you screen and assess clients with COD.*
Sustainability of Screening and Assessment Curriculum		*Are you still using the screening and assessment tools? If not, why not?*
Barriers to using Screening and Assessment Curriculum		*Tell me about the barriers to using the curriculum to help you screen and assess clients with COD.*
Integrating Combined Therapies Curriculum (#2)	Tell me about your use of the Integrating Combined Therapies Curriculum.	
Adoption of Integrating Combined Therapies Curriculum		*Did you use the ICT curriculum to treat clients with COD? Why or why not?*
Utility of ICT Curriculum		*Tell me about the usefulness of the ICT curriculum in helping you treat clients with COD.*
Sustainability of Combined Therapies Curriculum		*Are you still using the ICT curriculum? If not, why not?*
Barriers to using Combined Therapies Curriculum		*Tell me about the barriers to using the curriculum to help you treat clients with COD.*
Cognitive-Behavioral Therapy Curriculum (#3)	Tell me about your use of the Cognitive Behavioral Therapy Curriculum.	
Adoption of Cognitive-Behavioral Therapy Curriculum		*Do you or did you use the CBT curriculum to treat clients with COD? Did you use the materials provided? Why or why not?*

Table D.1—Continued

Topic	Question to Initiate Discussion	Possible Prompts/Probes
Utility of CBT curriculum		*Tell me about the usefulness of the CBT curriculum in helping you treat clients with COD.*
Sustainability of Cognitive-Behavioral Therapy Curriculum		*Are you still using the CBT curriculum? If not, why not?*
Barriers to using Cognitive-Behavioral Therapy Curriculum		*Tell me about the barriers to using the curriculum to help you treat clients with COD.*
Medication Management Curriculum (#4)	Tell me about your use of the Medication Management Curriculum.	
Adoption of Medication Management Curriculum		*Do you or did you use the MM curriculum to assist you in treating clients with COD? Did you use the materials provided? Why or why not?*
Utility of MM Curriculum		*Tell me about the usefulness of the MM curriculum in helping you treat clients with COD.*
Sustainability of Medication Management Curriculum		*Are you still using the MM curriculum? If not, why not?*
Barriers to using Medication Management Curriculum		*Tell me about the barriers to using the curriculum to help you treat clients with COD.*

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In recent years, the prevalence of psychological health conditions among military service members has increased substantially. Patients with co-occurring psychological health and substance abuse conditions have unique treatment needs, and evidence suggests that integrated treatment for these conditions may be more effective than treating each separately. The Navy's Bureau of Medicine contracted with Hazelden to provide training for clinicians to deliver an evidence-based intervention for treating patients with co-occurring disorders. The Hazelden training, the Co-Occurring Disorders Clinician Training Program (CODP), began in 2008.

RAND evaluated the implementation of the training among Substance Abuse Rehabilitation Program (SARP) personnel to understand the CODP approach and goals, and to describe the training program and materials and trainee perceptions, identify which program elements were implemented and sustained, identify facilitators and barriers to implementation, and describe programs' capabilities to provide integrated care.

This report presents the results and makes recommendations for improving training of SARP personnel. RAND researchers formulated the following recommendations: Develop a training plan, obtain leadership support, plan for staff turnover, provide consultation after training, and evaluate training efforts; ensure that clinician training focuses on materials and skills most relevant to their practice; consider requiring that all service members receiving care from a SARP be screened for substance use and psychological health problems; identify and certify select sites as providing enhanced co-occurring disorders services; and implement measures to assess the quality of care at SARPs.

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